

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and in any event, within 24 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13536

13548

1. DECEASED-NAME (Type or print) <b>LYDIA V. ANGLE</b>		First Middle Last		2a. DATE OF DEATH <b>Sept. 20 1968</b>		2b. HOUR <b>5:30 A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>9/23/1879</b>		6. AGE (In years last birthday) <b>88</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Co. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housekeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Penna.</b>		13b. COUNTY <b>Franklin</b>		13c. CITY OR TOWN <b>Greencastle</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>339 E. Balto. St.</b>		14. FATHER'S NAME First Middle Last <b>Daniel Shupp</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Saville Weller</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>4129</b>		17. INFORMANT <b>Mr. Geo. Stoffer - Greencastle, Pa.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease - 4129</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>6 cerebral hemorrhage - 2 days</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1939</b> , to <b>9/20, 1968</b> , that (I) (we) last saw the deceased alive on <b>9/19, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>W.C. Brewer, M.D.</b>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9/20/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>W.C. Brewer, M.D.</b>		22e. ADDRESS <b>Greencastle, Pa.</b>					
23a. BURIAL, CREMATION, REBURY (Specify) <b>B.</b>		23b. DATE <b>9/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Browns Mill Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>RAUFFMAN STATION, PA</b>	
24. FUNERAL DIRECTOR <b>A.E. Minnich</b>		ADDRESS <b>Greencastle, Pa.</b>		25a. REC'D BY REGISTRAR <b>SEP 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

13218

U.S. DEPARTMENT OF AGRICULTURE

13218

13218

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

SEP 23 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH	
Harry		Omer		Barnes		September		27, 1968	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7b. HOUR	
Male		White		April 7, 1887		81		4:00P M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. IF UNDER 1 YEAR MONTHS DAYS	
Williamsport, Md.		U. S. A.				Washington		5 20	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Fairplay		Rfd. 1		Net. Machinist		Auto			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Fairplay		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rfd. 1	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME First Middle Last	
Thornton		C.		Barnes				Mary Catherine Ripple	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		1770 Rose View Dr.			
No.		376-05-5435		Mr. Robert O. Barnes		Columbus, Ohio			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenitive Heart Failure</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>4200</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>8-16-</u> , 19 <u>64</u> , to <u>9-27-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9-27-</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>9-28-68</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
JOSEPH SECONDARI		Boonsboro Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		9-30-68		Boonsboro Cemetery		Boonsboro, Wash. Co., Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John H. Bast, Jr.		112 N. Main St. Boonsboro, Md.		OCT 1 1968		Charles Judge			

John H. Smith, Jr., 112 N. Main St., Boonville, Mo.

Boonville, Mo., 9-30-88

Boonville, Mo., 9-30-88

Boonville, Mo., 9-30-88

Oct 1 1888

No. 100-00-000 Mr. Robert G. Smith, Columbia, Ohio  
G. Smith  
Hart  
G. Smith  
1910 Rose Ave.  
Columbia, Ohio

Resident

Washington

Virginia

Mo. 1

Religion

Rel. 1

Mr. Smith

Also

Illinois, Mr. W. S. A.

X

Washington

Male

White

April 1, 1887

Mo

2 30

Birth

Birth

December

27, 1888

1888

1888

1888



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/48

13538

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13550

1. DECEASED-NAME (Type or print) First Middle Last <b>Roy Orlando Barr</b>			2a. DATE OF DEATH Month Day Year <b>September 27 1968</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>October 12, 1893</b>	
6. AGE (In years last birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Washington</b> Md.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>129 Fairground Ave.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Contractor</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>	
13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>129 Fairground Ave.</b>	
14. FATHER'S NAME First Middle Last <b>Clarence A Barr</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Cora Elizabeth Dowler</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>AW 1 220-30-9600</b>		17. INFORMANT Address <b>Mrs. R.O. Barr, 129 Fairground Ave., Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4200</b> (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Infarction</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>instant</b> <b>10 yrs</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Pulmonary Embolism - Benign pneumonia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1944</b> to <b>Sept 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept 16, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Edson B. Moody</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>Edson B. Moody</b>				22e. ADDRESS <b>363 Cleveland Ave Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/1/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Hagerstown-Washington-Md.</b>					
24. FUNERAL DIRECTOR <b>Rest Haven Funeral Chapel</b>		ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 2 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

10

43

U.S. DEPARTMENT OF JUSTICE      OFFICE OF THE ATTORNEY GENERAL      100-12-025      100-12-025

Edison B. Moody  
203 Cleveland Ave. Hoboken, N.J.

100 5 000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13539

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13551

1. DECEASED-NAME (Type or print)		First <i>James</i>	Middle <i>nm</i>	Last <i>Barrett</i>	2a. DATE OF DEATH Month <i>September</i> Day <i>3</i> Year <i>1968</i>		2b. HOUR <i>7:05</i> P.M.			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>September 2, 1968</i>		6. AGE (In years lost birthday) YRS. <i>1</i>		IF UNDER 1 YEAR MONTHS <i>1</i>	IF UNDER 24 HRS. HOURS <i>1</i>	MIN.
7a. BIRTHPLACE (State or foreign country) <i>Hagerstown, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md.				
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>none</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>none</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>114 W. Franklin St.</i>		
14. FATHER'S NAME		First <i>Bernard</i>	Middle <i>Clark</i>	Last <i>Barrett</i>	15. MOTHER'S MAIDEN NAME		First <i>Patricia</i>	Middle <i>Ann</i>	Last <i>Gearhart</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown		16b. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address <i>Md. Hagerstown</i> <i>Bernard C. Barrett 114 W. Franklin St.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fetal atelectasis</i> <i>7769</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Prematurity (Premature Infant)</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>32 hours</i> <i>Life</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>7625</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>9/2</i> , 19 <i>68</i> , to <i>9/3</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9/3/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>George Jennings MD</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>9/5/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>George Jennings</i>				22e. ADDRESS <i>318 N. Potomac St. Hagerstown, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9/6/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Buck Hill Church Cemetery</i>		23d. LOCATION (City or Town)		(County) <i>Berkeley W. Va.</i>	(State)	
24. FUNERAL DIRECTOR <i>Wm. C. Hunt</i> <i>Rest Haven Funeral Chapel</i>				ADDRESS <i>Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 9 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

13721

13721

STATE OF NEW YORK

September 3, 1908

Notary

and

Justice

1

September 3, 1908

State

and

Washington

and

Washington

and

Washington County, New York

Washington

Washington

Washington

Washington

Washington

and

Washington

Washington

Washington

Washington

Washington, New York

and

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13540

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13552

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M		
Edward		Louis		Bell, Sr.	September 23 1968		9:30		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
Male	White		April 12, 1913		55				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Canonsburg, Pa.		USA				Washington Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington County Hospital		Owner & Operator		Cab Co. & Tavern			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Hagerstown				121 N. Ridge Dr.	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last							
Louis		Bell		Mary					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No		190-10-9674		Mrs. Florence Bell 121 N. Ridge Dr. Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension essential; stroke; diabetes; generalized ventricular fibrillation</u> 4201 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATING TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/25</u> , 19 <u>68</u> , to <u>9/23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9/23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
Edson B. Moody		9-24-68		Edson B. Moody, M.D.					
22e. ADDRESS		22f. ADDRESS							
363 S. Cleveland Ave.		Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		9/26/68		Rest Haven Cemetery		Hagerstown-Washington-Md.			
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. REC'D BY REGISTRAR		24c. REGISTRAR'S SIGNATURE			
Wm. G. Horst		Rest Haven Funeral Chapel Hagerstown, Md.		DATE SEP 27 1968		J. Charles Judge			



13722

13861

REPUBLIC OF CHINA

MINISTRY OF THE INTERIOR

1951

1951

1951

1951

1951

22

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951-10-10

1951

1951-10-10

1951-10-10

1951-10-10

1951-10-10

1951-10-10

1951-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Franklin</b> <b>Penna</b> <b>Washington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bruce Mortz Bishop</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>23</b> Year <b>1968</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 12, 1906</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern operator</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Adams Co, Penna.</b>	
13. FATHER'S NAME <b>J. Mark Bishop</b>		14. MOTHER'S MAIDEN NAME <b>Annie McCleef</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>162-10-6217</b>	
17. INFORMANT <b>Mrs. Bruce M. Bishop</b>		Address <b>Quincy, Penna.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>2029</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2029</b> (b) <b>Obstruction, superior vena cava</b> DUE TO (c) <b>Lymphoma, anterior mediastinum</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>4 wks.</b> <b>6 mon.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 14</b> , 19 <b>68</b> , to <b>Sept. 23</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Sept. 23</b> , 19 <b>68</b> , and that death occurred at <b>9:30 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. H. Kehne</b>		22b. DATE SIGNED <b>9-23-68</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. H. KEHNE, M. D.</b>		22d. ADDRESS <b>1229 Ravenswood Hts., Hag., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept. 26, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Quincy Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Quincy, Franklin, Penna.</b>
24. FUNERAL DIRECTOR <b>Walter J. Gure</b>		25a. REC'D BY REGISTRAR <b>SEP 26 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

18553

Franklin

9 days

Sept. 12, 1906 62

White

Tavern operator

J. Mark Bishop

U.S.A.

Adams Co, Penna.

Annie McCloud

Quincy, Penna.

Mrs. Bruce M. Bishop

102-10-0217

no

Quincy, Franklin, Penna.

Quincy Cemetery

Sept. 26, 1906

Burial

SEP 26 1906

Waynesboro, Penna.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First <b>Keefer</b>			Middle <b>David</b>			Last <b>Bowers</b>			2a. DATE OF OATH Month <b>9</b> Day <b>1968</b>			2b. HOUR <b>8:15</b> <sup>a</sup> M		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>10/19/98</b>			6. AGE (In years last birthday) <b>69</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>WASHINGTON</b> Md.								
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>painter</b>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Frederick</b>			13c. CITY OR TOWN <b>Thurmont</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>Rt. 1</b>					
14. FATHER'S NAME First <b>Eli</b>			Middle <b>David</b>			Last <b>Bowers</b>			15. MOTHER'S MAIDEN NAME First <b>Lillie</b>			Middle <b>Belle</b>			Last <b>Weddle</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <b>yes</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>213-10-2401</b>			17. INFORMANT <b>Earle W. Bowers</b>			Address <b>Thurmont, Md. RD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>203x</b> IMMEDIATE CAUSE (a) <b>Multiple myeloma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr. 5 mo.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>203x</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D.-No. City or Town County State											
22a. I certify that (I) (the hospital) attended the deceased from <b>6/18</b> , 19 <b>68</b> , to <b>9/9</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>Sept. 9</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Domingo A. Garcia</b>			DEGREE <b>M.D.</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>9/9/68</b>								
22d. PHYSICIAN'S NAME (Type) <b>Domingo A. Garcia, M.D.</b>			22e. ADDRESS <b>1500 Pennsylvania Ave., Hagerstown, Md.</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>9-12-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Lewistown Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Lewistown Fred. Co. Md.</b>								
24. FUNERAL DIRECTOR <b>Raymond E. Creager</b>			ADDRESS <b>Thurmont, Md.</b>			25a. REC'D BY REGISTRAR <b>SEP 13 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								

INFORM

112

11

... ..



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

79  
10  
2  
1  
4  
10  
2

13543

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13555

1. DECEASED-NAME (Type or Print) <b>Walter L. Brown</b>			2a. DATE KNOWN <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR <input type="checkbox"/> M		
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>2-22-1925</b>	6. AGE (In years last birthday) <b>43</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>
7a. BIRTHPLACE (State or foreign country) <b>Fred. Co</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Co. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Fred.</b>		13c. CITY OR TOWN <b>Thurmont</b>	
14. FATHER'S NAME <b>John T. Brown</b>		15. MOTHER'S MAIDEN NAME <b>Mettie W. Wilhide</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW 11</b>		17. INFORMANT ADDRESS <b>Doris S. Brown Thurmont, Md. RD 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compression Fracture of C5</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Trans-section Spinal Cord</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Marked Cerebral Edema</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>52 hrs.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>910.3</b>					
19a. DATE OF OPERATION <b>9-26-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fracture C5 - Reduction of:</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>10-26-68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Bulk Bins of Apples Fall off Fork lift Truck</b>	
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Storage Building</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>Rt # 2 Thurmont Fred. Md</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Edward W. Dito III</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>9-28-68</b>	
EXAMINER'S NAME (Type) <b>217 W. Washington St. Hagerstown, Md</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-2-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Memorial</b>	
24. FUNERAL DIRECTOR <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 4 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
23d. LOCATION (City or Town) (County) (State) <b>Frederick Fred. Co. Md.</b>					

13552

UNITED STATES DEPARTMENT OF AGRICULTURE

13552

UNITED STATES DEPARTMENT OF AGRICULTURE

10

M

1

13552

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
LENA			DE GROOT			Buys			Sept 4 1968 9 P M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		July 4 1877			91 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		USA				Washington Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Boonsboro		Fahrney- Keedy Mem Home			Housewife		Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Hagerstown		YES		42 Broadway	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
George De Groot			Elizabeth (unknown)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No		None		George H. Buys 1039 Hamilton Blvd Hagerstown Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Arteriosclerotic cardiovascular disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from May 4, 1968, to Sept 4, 1968, that (I) (we) last saw the deceased alive on Sept 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
G. W. Latham M.D.		Sept 5, 1968							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
G. W. Latham M.D.		Boonsboro, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		9/7/68		Rest Haven Cemetery		Hagerstown Wash Co Md.			
24. FUNERAL DIRECTOR Hagerstown Md. ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Andrew K. Coffman Funeral Home Inc				SEP 9 1968		Charles Judge			

1355

1355

LENA	DE GROOT	BYYS	Sept 4 1904	2 2
female	white	July 4 1877	21	
New Jersey	USA	X	Washington	
Brookside	Fairview-Kedy New Home	Housewife	Own Home	
Washington	Washington	X	12 Broadway	

George De Groot  
 Elizabeth (unknown)  
 George H. Buys 1030 Hamilton Blvd  
 Washington D.C.

Burial 2/7/08 West Haven Cemetery Washington D.C.  
 Andrew K. Coffin Funeral Home Inc 829 2 100  
 Washington D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Myrtle Leila Charles						September 7, 1968		11:15 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
female		white		11-6-1876		91 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Washington Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Maugansville			Maugansville Nursing Home							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Wash.		Hagerstown				605 Brighton, Place	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
Milton Charles				Amanda Eversole						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no				214-32-4314		Mrs. Sara Rowe Smithsburg, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 DUE TO, OR AS A CONSEQUENCE OF Pneumonia (Bilateral)										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary Anemia 1 year.										
(c) DUE TO, OR AS A CONSEQUENCE OF General Arterio Sclerosis 10 yrs.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500 Stomach										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan 10, 1960 to Sept 7, 1968, that (I) (we) last saw the deceased alive on Sept 7, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE J. H. Beachley M.D. 22c. DATE SIGNED 9/9/68										
22d. PHYSICIAN'S NAME (Type) J. H. Beachley M.D. 22e. ADDRESS Hagerstown, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		9-10-1968		Rose Hill Cemetery		Hagerstown, Md.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Minnich Funeral Home Hagerstown, Md.				DATE SEP 11 1968		J. Charles Judge				



1855

1855

1855

September 7, 1855

Charles

John

George

11-6-1855

John

John

September

X

John

John

John

Newmanville

Newmanville

305 Madison, Ill.

X

John

John

Amelia

John

11-6-1855

John

John

John

John

John

John

John

John

John

John

John

John

John

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)  
30M REV. 1/52

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>Ella</b> <b>Hoffman</b> <b>Coffman</b>			2a. OATE OF OATH Month <b>Sept.</b> Day <b>30</b> Year <b>1968</b>			2b. HOUR <b>M</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 31 1873</b>		6. AGE (In years lost birthday) <b>95</b> YRS.		IF UNDER 1 YEAR MONTHS <b>6</b> DAYS <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.				
10. CITY OR TOWN OF DEATH <b>Boonsboro</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Home</b> <b>Farmney Keedy Memorial</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Downsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Downsville Rural</b>	
14. FATHER'S NAME First <b>Benjamin</b> Middle <b>Franklin</b> Last <b>Hoffman</b>			15. MOTHER'S MAIOEN NAME First <b>Maria</b> Middle <b>Nikirk</b> Last <b>Nikirk</b>							
16a. WAS DECEASED EVER IN U.S. ARMOED FORCES? Yes, no, or unknown <b>No</b> (If yes give war and dates of service)			16b. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Mrs. T. W. Campbell Downsville Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interoskeletal cardio Vascular Disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONOITION GIVEN IN PART 1(a) <b>4221</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINOINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 14, 1968</b> , to <b>Sept 30, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept 23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>G.W. Levan M.D.</b>					22c. DATE SIGNED <b>Oct 1, 1968</b>			22d. PHYSICIAN'S NAME (Type) <b>G.W. Levan M.D.</b>		
22e. ADDRESS <b>Boonsboro, Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. OATE <b>Oct 2-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Keedysville Washington Md.</b>				
24. FUNERAL DIRECTOR <b>Albert L. Leaf Williamsport, Maryland</b>					25a. REC'D BY REGISTRAR DATE <b>OCT 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

13558

DEPARTMENT OF AIR

13558

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several lines of text, some of which may be names or titles, but they cannot be accurately transcribed.]

13558  
[Faint vertical text and markings on the right margin, including what appears to be a date and some illegible notes.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

<div style="display: flex; justify-content: space-between;"> <span>13547</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>13559</span> </div>											
1. DECEASED-NAME (Type or print) <b>Carl Thomas Cookerly</b>						2a. DATE OF DEATH Month <b>September</b> Day <b>6</b> Year <b>1968</b>			2b. HOUR <b>4:30</b> M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 12, 1900</b>			6. AGE (In years last birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Co. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired M. Operator</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Creek Road-Route 2</b>		
14. FATHER'S NAME First <b>John T.</b> Middle <b>Cookerly</b> Last <b></b>				15. MOTHER'S MAIDEN NAME First <b>Lillian</b> Middle <b>Parker</b> Last <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b></b>		17. INFORMANT Address <b>Mrs. Edna Cookerly, Cumberland, Md. Wife</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>430.9</b> IMMEDIATE CAUSE (a) <b>Bilateral Cerebral Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Spasm associated with subarachnoid hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ruptured aneurysm, right internal carotid artery</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>4 weeks</b> <b>4 weeks</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>330X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>August 10, 1968</u> , to <u>Sept. 6, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Sept. 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>A. F. Abdullah M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>9/6/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>A. F. Abdullah, M.D.</b>						22e. ADDRESS <b>318 N. Potomac, Hagerstown, Md. 21740</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 9, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>				
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>SEP 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

13559

13559

450

December 6, 1908 A.

Cooperatively

Thomas

Carl

White

Male

Washington

Washington Co. Hospital

Hagerstown



NO COPY OF RECORDS  
SHOULD BE DESTROYED  
UNTIL THE  
RECORDS  
ARE  
REMOVED  
FROM  
THE  
FEDERAL  
BUREAU  
OF  
INVESTIGATION  
AND  
RECORDS  
MANAGEMENT  
DIVISION  
OF  
THE  
DEPARTMENT  
OF  
JUSTICE  
AND  
THE  
FEDERAL  
BUREAU  
OF  
INVESTIGATION  
AND  
RECORDS  
MANAGEMENT  
DIVISION  
OF  
THE  
DEPARTMENT  
OF  
JUSTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 4 Film G405 10/3/68 JCS											
13548		13560									
1. DECEASED-NAME (Type or print) <b>CHARLES ANDREW CROUSE</b>						2a. DATE OF DEATH Month <b>Sept.</b> Day <b>26</b> Year <b>68</b>			2b. HOUR <b>7:10PM</b>		
3. SEX <b>M</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Aug. 26, 1884</b>			6. AGE (In years lost birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Fulton Co., Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Washington</b> Md.				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Stone Mason</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Pa</b>		13b. COUNTY <b>Fulton</b>		13c. CITY OR TOWN <b>Big Cove Tannery</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Thompson Twp.</b>			
14. FATHER'S NAME First <b>Jacob</b> Middle <b>Crouse</b> Last <b>Crouse</b>				15. MOTHER'S MAIDEN NAME First <b>Annie</b> Middle <b>Hess</b> Last <b>Crouse</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Walter Crouse, Big Cove Tannery, Pa.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> <b>485x</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>491x</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arteriosclerotic heart disease. Biliary cirrhosis</b>											
19a. DATE OF OPERATION <b>9-21-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Obstructive jaundice</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 16</b> , 19 <b>68</b> , to <b>Sept. 26</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Sept. 26, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>J. H. Kehne M.D.</b>						DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9-27-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>J. H. KEHNE, M. D.</b>						22e. ADDRESS <b>1229 Ravenwood Hts., Hag., Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 29, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union</b>			23d. LOCATION (City or Town) (County) (State) <b>Agar Twp. Fulton Co., Pa.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Minnich Funeral Home, Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

MEDICAL CERTIFICATION

2

79  
75  
3

1

13560

13560

25 JUL 68

256

256

256

256

256

256

256

256

256

256

256

256

256

256

256

256

256

256

256

256

256

256

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and ready for the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
13549					13561						
1. DECEASED-NAME (Type or print) Katherine Elizabeth Diehl					2a. DATE OF DEATH - Month Sept. 9, 1968			2b. HOUR a 9:15 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Oct. 1, 1899			6. AGE (In years lost birthday) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garlock Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna.			13b. COUNTY Franklin		13c. CITY OR TOWN Waynesboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 34 E. Third St.		
14. FATHER'S NAME First Middle Last George Hartle				15. MOTHER'S MAIDEN NAME First Middle Last Fannie Cordell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no				16b. SOCIAL SECURITY NO. 173-03-0326D		17. INFORMANT Mr. William R. Diehl				Address Waynesboro, Penna.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease &amp; CHF</i> 250.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Diabetes mellitus</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c) <i>260.0</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Blunt and sharp injuries</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1/9, 1968, to 9/9, 1968, that (I) (we) last saw the deceased alive on 9/9/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>Wm O. Ryder</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 9/9/68			
22d. PHYSICIAN'S NAME (Type) 145 S. Prospect St.,				22e. ADDRESS Hagerstown, Md. 21740							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/11/1968		23c. NAME OF CEMETERY OR CREMATORY Green Hill			23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Pa.				
24. FUNERAL DIRECTOR <i>Walter J. Shore</i>				ADDRESS Waynesboro, Penna.		25a. REC'D BY REGISTRAR SEP 10 1968		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

13561

Sept. 2 1938 9:12

Oct. 1, 1939

08

XXXXXX

White

Female

Washington

X

U.S.A.

Penn.

Honolulu

Carlisle Nursing Home

Hagerstown

3d E. Third St.

X

Weynesboro

Franklin

Penn.

Gonzalez

Fannie

Marjorie

George

Weynesboro, Penn.

173-02-0320 Mr. William R. Diehl

no

Weynesboro, Franklin, Pa.

Green Hill

2/17/38

Marjorie

Weynesboro, Penn. SEP 10 1938

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13550									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
13562									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR	
Harvey Reichard Domer						9-17-68 19		11:00 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
male	white	12-12-96	71 YRS.			9 18 1968		8:45 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Washington			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Big Spring			RFD 1			truck driver			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.			Wash.			Big Spring		RFD 1	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
George W. Domer			Florence R. Kendle						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
no			214-09-3595			George Domer, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunsnot wound Abdomen</u> 955 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Twisted</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 976 X									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month Day Year HOUR A.M. P.M. 11:00 9-17-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Self inflicted gunshot wound Abdomen</u>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>Chas. Hill Rd Clear Spring Wash Md</u>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Edward W. Ditto, III</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 9-19-68			
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			217 W. Wash. St. Hagerstown, Md.			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
burial		9-20-68		Rose Hill Cemetery		Hagerstown, Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Minnich Funeral Home, Hagerstown, Md.				SEP 23 1968		Charles Judge			



15505

15505

RECEIVED

(M)

(1)

NAVY

12-1-58

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

15505

NAVY

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13551 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												13563			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print)			First <b>Ellis</b>			Middle <b>George</b>			Last <b>Duffey, Sr.</b>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>9-19-68</b> 19		2b. HOUR <b>8:30</b> PM	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>12-22-1903</b>		6. AGE (In years last birthday) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <b>9 19 1968</b>		2d. HOUR <b>8:30</b> PM	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Washington</b> Md.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. County Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Sales Representative</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Farm Bldgs</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Wash.</b>				13c. CITY OR TOWN <b>Funkstown</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>223 E. Baltimore, St.</b>			
14. FATHER'S NAME First Middle Last <b>Edward C. Duffey</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Lily Dick</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>214-09-3140</b>		17. INFORMANT ADDRESS <b>Mrs. Jane E. Duffey, Sr. Funkstown, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
												PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>Edward W. Dittolli</b> M.D. EXAMINER'S NAME (Type) <b>Edward W. Dittolli</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>9-20-68</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-22-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beaver Creek Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Washington, County, Maryland</b>							
24. FUNERAL DIRECTOR ADDRESS <b>Minnich Funeral Home Hagerstown, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>SEP 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)  
30M REV. 11-66

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13552

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>MARIAN</b>			First	Middle	Last	2a. DATE OF DEATH Month <b>9</b> Day <b>68</b> Year			2b. HOUR <b>6:15</b> M					
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>AUGUST 16, 1923</b>			6. AGE (In years last birthday) <b>45</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>NEW JERSEY</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>WASHINGTON</b>			Md.		
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>829 VIRGINIA AVE.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>DESK CLERK</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>HAMILTON HOTEL</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>WASHINGTON</b>			13c. CITY OR TOWN <b>HAGERSTOWN</b>			13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			13e. STREET AND NUMBER <b>829 VIRGINIA AVE.</b>		
14. FATHER'S NAME First <b>WILLIAM</b> Middle <b>BANKS</b> Last <b>BANKS</b>			15. MOTHER'S MAIDEN NAME First <b>MINNIE</b> Middle <b>REED</b> Last <b>REED</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>148-16-6990</b>			17. INFORMANT <b>WILLIAM DURLING, 829 VIRGINIA AVE, HAGERSTOWN</b>			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive CV Dis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>5 years</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4201</b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>1-1</b> , 19 <b>67</b> , to <b>9-9</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>9-9</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Robert P. Conrad, M.D.</b>			DEGREE <b>MD</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>9/10/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>ROBERT P CONRAD, M.D.</b>			22e. ADDRESS <b>137 W. WASHINGTON, HAGERSTOWN, MARYLAND</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>9/13/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN, WASHINGTON, MD.</b>					
24. FUNERAL DIRECTOR <b>Charles M. Ronger</b>			ADDRESS <b>HAGERSTOWN, MARYLAND</b>			25a. REC'D BY REGISTRAR <b>SEP 13 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

13564

RECEIVED

13564

DATE: 10/10/54

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/54

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/54

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/54

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-68  
30M REV. 7-68

13553		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				13565					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Leah		Emma		Ebersole		Sept.		Month 5 Day 1968		3:28 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Oct. 26, 1992		75 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Hagerstown, Md.		U.S.A.				Washington Co.		Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown, Md.		Washington Co. Hos.		House work		Home duties					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Washington		Clear Spring				Route 1			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
William Harrison Angle								Florence May Eyerly			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		None		490-24-2059		Arville L. Ebersole		Clear Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic pulmonary carcinoma</u> <u>174X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 yr. 4 mo.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>170X</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>April 27, 1964</u> , to <u>Sept. 5, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept. 4, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>B. B. Kneisley</u>		M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>9/7/68</u>					
22d. PHYSICIAN'S NAME (Type)		B. B. Kneisley, M.D.		22e. ADDRESS <u>148 West Washington Street</u> <u>Hagerstown, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		9/9/68		St. Pauls Cemetery		Clear Spring Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE					
<u>Margaret Rawland</u>		Clear Spring, Md.		SEP 11 1968		<u>Charles Judge</u>					

13565

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

10/1/58

10/1/58

2

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

10/1/58

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <b>Earl C. Eckenrode</b>			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 9 15 1968			2b. HOUR 5:45 P.M.		
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>8-16-1903</b>	6. AGE (in years last birthday) <b>65</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 9 Day 15 Year 1968		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Washington Co. Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Orchards</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Fred.</b>		13c. CITY OR TOWN <b>Thurmont</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RD 2</b>
14. FATHER'S NAME First Middle Last <b>Cleophas Eckenrode</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Etta May Myers</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-28-2188A</b>		17. INFORMANT ADDRESS <b>Thelma Stackhouse Thurmont, Md RD2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture st. occipital area - 2 lesions</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>base left frontal + left temporal lobe +</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>left lobe cerebellum due to laceration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 days?</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>9369</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>9-7-1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Apparently involved in Fight</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Thurmont</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>Thurmont Frederick Md.</b>				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>								
ACTUAL SIGNATURE <b>Edward W. Ditto, Jr.</b>		EXAMINER'S NAME (Type) <b>DR. E.W.DITTO 111 217 W. WASH. ST. HAGERSTOWN, MD.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>9-15-68</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-18-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Thurmont Fred Co. Md.</b>		
24. FUNERAL DIRECTOR <b>Raymond E. Greger</b>				ADDRESS <b>Thurmont, Md</b>		25a. REC'D BY REGISTRAR <b>SEP 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

13566

EXHIBIT EXAMINER'S REPORT

STATE OF TEXAS  
COUNTY OF DALLAS

(M)

1

THE EXHIBIT IS THE PROPERTY OF THE STATE OF TEXAS

EXHIBIT NO. 13566

SEP 13 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13555										13567									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)			First <b>Alma</b>			Middle <b>Martin</b>			Last <b>Elliott</b>			2a. DATE OF DEATH Month <b>September</b> Day <b>30</b> Year <b>1968</b>				2b. HOUR <b>11:00AM</b>			
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>May 8, 1882</b>				6. AGE (In years lost birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b>		IF UNDER 24 HRS. HOURS <b>00</b> MIN. <b>00</b>					
7a. BIRTHPLACE (State or foreign country) <b>Tennessee</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Washington</b> Md.										
10. CITY OR TOWN OF DEATH <b>Boonsboro</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Fahrney- Keedy Mem. Home</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Virginia</b>			13b. COUNTY <b>Arlington</b>			13c. CITY OR TOWN <b>Arlington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>525 Monroe St.</b>									
14. FATHER'S NAME First <b>George</b>			Middle <b>W.</b>			Last <b>Martin</b>			15. MOTHER'S MAIDEN NAME First <b>Mattie</b>			Middle <b>Kimbrough</b>			Last <b>Kimbrough</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>			16b. SOCIAL SECURITY NO. <b>579-62-6043</b>			17. INFORMANT Address <b>Mr. Joe W. Elliott, Rfd. 2 Boonsboro, Md.</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4221</b>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 30</b> , 19 <b>68</b> , to <b>Sept 30</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Sept 30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <b>G.W. LeVan</b>														22c. DATE SIGNED <b>Sept 30, 68</b>					
22d. PHYSICIAN'S NAME (Type) <b>G.W. LeVan</b>														22e. ADDRESS <b>Boonsboro, Md.</b>					
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>			23b. DATE <b>Oct. 2, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mount Comfort Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Alexandria, Va.</b>										
24. FUNERAL DIRECTOR ADDRESS <b>Ives Funeral Home 2847 Wilson Boulevard Arlington, Virginia</b>																			
25a. REC'D BY REGISTRAR DATE <b>OCT 3 1968</b>										25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									



5022

00:11 8981 01 10000000

115

013184

2. 4. 1.

S337 . O 724

4. *in*

James?

• 1 • 2 • 0

628 0722

01262200

01061176

not patient

3570-36

Mr. J. H. Hill, Jr., 100 N. 1st St., St. Paul, Minn.

•

Altenstein

Home County Cemetery

## Findings

6891 3 130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (1)  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2c. DATE OF DEATH Month Day Year			2b. HOUR A.M. M
LEWIS			RALPH FAULDER			Sept 8 1968			5.50
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		Nov 27 1911		56 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Md.			
Maryland		U.S.A.				Washington			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Wash County Hospital			Fireman		R.R.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Washington		Hagerstown		xx		1417 Salem Ave
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Joseph L. Faulder			Loretta Brewer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No --			705-10-5750		Mrs Mildred C. Faulder 1417 Salem Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>Indefinite</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 <u>Hypertension, essential</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR-A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>3-14</u> , 19 <u>58</u> , to <u>death</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>5-8</u> 19 <u>68</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.									
22b. SIGNATURE <u>Robert F. Keadle</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>9-9-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Robert F. Keadle</u>						22e. ADDRESS <u>Hagerstown Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			9/10/68		Rest Haven Cemetery		Hagerstown Wash Co Md.		
24. FUNERAL DIRECTOR <u>Hagerstown Md</u> <u>Andrew K. Coffman Funeral Home Inc</u>						25a. REC'D BY REGISTRAR DATE <u>SEP 13 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13558

13558

Sept 8 1908

PAULSEN

RAVEN

LEWIS

Nov 27 1911

White

White

x

Washington

U.S.A.

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201: 13569  
13557  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>ALMA GRACE FOREMAN</b>			2a. DATE OF DEATH Month <b>Sept.</b> Day <b>3</b> Year <b>1968</b>			2b. HOUR <b>9:45 A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>4/7/1904</b>		6. AGE (In years last birthday) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Storbeck Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13a. USUAL RESIDENCE (Where deceased lived, or institution: Residence before admission) <b>Penna.</b>		13b. CITY OR TOWN <b>Franklin</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <b>Williamson, Pa.</b>			
14. FATHER'S NAME First <b>John</b> Middle <b>Baer</b> Last <b>Baer</b>			15. MOTHER'S MAIDEN NAME First <b>Alice</b> Middle <b>Hassler</b> Last <b>Hassler</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (known) (If yes give War or dates of service)			16b. SOCIAL SECURITY NO. <b>4409</b>			16c. INFORMANT <b>Robert J. Foreman</b> Address <b>Williamson, Pa.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Syndrome Due To Cerebral Atrophy</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Vascular Disease, Severe</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4500</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>66</b> , to <b>Sept. 3</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>July 26</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>A. E. W. Ditte, Jr.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>Sept. 4, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dr. E. W. Ditte, Jr.</b>						22e. ADDRESS <b>215 W. Washington St., Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REPOSS. (Specify) <b>B.</b>		23b. DATE <b>9/6/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Upton Brethren Cem. - Upton, Pa.</b>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>A. E. Munnich - Greencastle, Pa.</b>				25a. REC'D BY REGISTRAR <b>SEP 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

92721

✓



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician. Page 5 is to be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13558

13570

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Morgan</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hancock, W. Va.</b>	
c. LENGTH OF STAY IN 1b <b>6 Days</b>		d. STREET ADDRESS <b>c/o Postmaster</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Type or print) <b>Ethel Virginia Fox</b>		4. DATE OF DEATH Month <b>September</b> Day <b>6</b> Year <b>19 68</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 7, 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	9. AGE (In years last birthday) <b>63 yrs.</b>
13. FATHER'S NAME <b>A. VanGosen</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>Icy Crouse</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myocardial Infarction</b> DUE TO (c) <b>Coronary atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>6 days.</b> <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4201</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 31, 1968</b> to <b>Sept 6, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept 6, 1968</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr Charles Spencer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <b>Hagerstown, Md.</b>		22e. ADDRESS <b>145 S. Prospect, Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/9/1968</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Alpine Church Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Hancock, (Morgan) W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>CE Johnson</b>		25a. REC'D BY REGISTRAR <b>SEP 16 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>Berkeley Springs, W. Va.</b>	

13270

STATEMENT OF DATA

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

13270

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13559												MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 6 Film G40-102768-1*												13571											
1. DECEASED-NAME (Type or print) First Middle Last Amelia J. Freudenberg						2a. DATE OF DEATH Month Day Year 9 15 68						2b. HOUR 6:05 PM																							
3. SEX F				4. RACE W.				5. DATE OF BIRTH 11-19-1884				6. AGE (In years lost birthday) 83 84 YRS.				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.																			
7a. BIRTHPLACE (State or foreign country) Md				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Washington Md.																							
10. CITY OR TOWN OF DEATH Williamsport				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Homewood Church Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE Md				13b. COUNTY AA				13c. CITY OR TOWN Pasadena				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER Bar Harbor																			
14. FATHER'S NAME First Middle Last George J. Schmidt				15. MOTHER'S MAIDEN NAME First Middle Last Ida E. Schmidt																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no				16b. SOCIAL SECURITY NO. 219-54-10377				17. INFORMANT Mark E. Wagner				Address 2750 W. Ave Williamsport, Md 21795																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive V Dis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>lost.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 10 years																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (this hospital) attended the deceased from 6-15, 1966 to 9-15, 1968, that (I) (we) last saw the deceased alive on 9-13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE Robert P. Corrao, M.D.												22c. DATE SIGNED 9-15-68																							
22d. PHYSICIAN'S NAME (Type) Robert P. Corrao												22e. ADDRESS Stagerstown, Md.																							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 9/18/68				23c. NAME OF CEMETERY OR CREMATORY Woodmont Park Cem.				23d. LOCATION (City or Town) (County) (State) Baltimore, Wash. Md																							
24. FUNERAL DIRECTOR W. T. Norman, Hagerstown, Md.												25a. REC'D BY REGISTRAR DATE SEP 19 1968				25b. REGISTRAR'S SIGNATURE J. Charles Judge																			

13271

LIBRARY OF CONGRESS

Washington

1871

1871

2 years  
10 years

Coram and Richardson  
Agreement & this

1871-72 1872-73 1873-74

1874-75  
Agreement from Mr.

Robert T. Coram  
Robert T. Coram

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30MA REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Phoebe		Middle Alice		Last Grove		2a. DATE OF DEATH Sept. Month 24 Day 1968 Year		2b. HOUR A 6:50M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 10/4/78			6. AGE (In years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH WASHINGTON Md.				
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) homemaker			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 14 West Long Meadow Rd.		
14. FATHER'S NAME First John			Middle C.			Last Weller			15. MOTHER'S MAIDEN NAME First SOPHIA			Middle C. Last Frushour	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) No			16b. SOCIAL SECURITY NO. (If give war or dates of service) 214-09-5889			17. INFORMANT MISS ADA GLADYS GROVE			HAGERSTOWN MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular accident; cardiac hypertrophy</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours many years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>8/13</u> , 19 <u>68</u> , to <u>9/24</u> , 19 <u>68</u> , that (I) <u>was</u> last saw the deceased alive on <u>Sept. 23</u> , 19 <u>68</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) <u>not</u> view the body after death.													
22b. SIGNATURE <u>Fe U. Porciuncula</u>			DEGREE M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 9/24/68				
22d. PHYSICIAN'S NAME (Type) Fe U. Porciuncula, M.D.			22e. ADDRESS Western Md. State Hospital 1500 Pennsylvania Ave., Hagerstown, Md.										
23a. BURIAL, CREMATION, OTHER			23b. DATE 9/25/68		23c. NAME OF CEMETERY OR CREMATORY ST. PAULS CHURCH			23d. LOCATION (City or Town) (County) (State) WASHINGTON MD.					
24. FUNERAL DIRECTOR <u>W. J. Norment</u>			ADDRESS Hagerstown, Md.			25a. REC'D BY REGISTRAR DATE OCT 1 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



13572

OFFICE OF THE

13572

Name

Age

Sex

Race

Address

City

State

County

Occupation

Education

Marital

Status

Employment

Employer

Previous

Employment

Employer

Date

Time

Place

Method

Result

Remarks

100-3-303

100-3-303

100-3-303

Company

Hypertension and associated diseases

On examination, patient was found to be

X

Date

Time

Place

Method

WV-100

Date

Time

Place

Method

100-3-303

100-3-303

100-3-303

OCT 1 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AT 15  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
13561		13573									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Charles William Guessford						Month Day Year			24 22 1968		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS	
Male		White		May 15 1899			69 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY	
Md. Washington		U.S.A.		Washington			Washington			Refrigeration	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington County			Machine Operator			Refrigeration		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md. Washington			Smithsburg			Rural # 1					
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Samuel Jonas Guessford			Nervie - Shaffer								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
no			213-18-9568			Mrs. Mary Robinson Smithsburg # 1					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Myocardial infarction										9 hrs.	
DUE TO, OR AS A CONSEQUENCE OF											
(b) Atherosclerotic heart disease										10 + yrs.	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Rheumatoid arthritis, Pulmonary hypertension											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 9/22, 19, to 9/22, 19, that (I) (we) last saw the deceased alive on 9/22/68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE											
22c. PHYSICIAN'S NAME (Type)											
22d. ADDRESS											
22e. DATE SIGNED 9/23/68											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Sept. 24		Smithsburg Cemetery		Smithsburg Washington Md.					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Minnich Funeral Home				Smithsburg Md.		DATE SEP 26 1968 J. Charles Judge					

13252

2551

1

8281 2 5 932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P		
James Leroy Hart						Sept 16 1968			10:07 PM		
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		Colored		Nov 16 1906				61 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Connellsville, Pa.			USA						Washington Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown Md			Washington County Hosp.				Laborer				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Washington		Hagerstown		YES		120 W. North Street		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Zail Hart			Carrie Mill								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
Yes			World War 2			Mrs. Ella W. Hart 120 W. North St					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANEXIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>massive pulmonary hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Active pulmonary tuberculosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 MINUTES</u> <u>5 MIN</u> <u>6 MONTHS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>0021</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>			
9-11-68		<u>removal of infiltrate</u>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>8-30</u> , 19 <u>68</u> , to <u>9-16</u> , 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>9-16</u> , 19 <u>68</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.											
22b. SIGNATURE <u>John H. Kehue MD</u> DEGREE								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>9-17-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>JOHN H. KEHUE</u>								22e. ADDRESS <u>1229 Ravenwood Hts Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		Sept 20 1968		Rose Hill Cemetery			Hagerstown Wash. Md.				
24. FUNERAL DIRECTOR <u>John R Watson of Hagerstown Md.</u>						25a. REC'D BY REGISTRAR DATE <u>SEP 19 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1324

1991

*[Faint handwritten notes at the bottom of the page]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1  
30M REV. 1-69

13563				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				13575				
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH				2b. HOUR	
Lewis Benjamin Henderson							Month 21 Day 1968				11:35 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male		Colored		Nov 11 1881		86 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Williamsport Md.		USA				Washington Md.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY						
Hagerstown Md		Avalon Manor		Laborer								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Maryland		Washington		Hagerstown				651 Pennsylvania Ave				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last			
John Henderson					Anna Keller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address						
no		215-20-8884		Joseph Henderson		651 Pennsylvania Ave						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Chronic urinary retention										4 weeks		
DUE TO, OR AS A CONSEQUENCE OF												
(b) Carcinoma of prostate										unknown		
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
Pulmonary emphysema												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
		HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION								
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (the hospital) attended the deceased from August 21 19 68, to September 21 19 68, that (I) (we) last saw the deceased alive on Sept. 4 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we do not) view the body after death.												
22b. SIGNATURE										22c. DATE SIGNED		
[Signature]										September 23,		
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS		
William T. Layman, M.D.										100 Professional Arts Bldg. Hagerstown, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)				
Burial		9-25-1968		Riverview Cemetery		Williamsport Wash		Md.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
John R Watson				Hagerstown Md.		DATE SEP 24 1968		Charles Judge				

13575

13568

CERTIFICATE OF DEATH

Chronic kidney retention

Carcinoma of prostate

Enlargement of prostate

August 21, 1968

28

Sept. 1

*William T. Layman, M.D.*

William T. Layman, M.D.

100 Professional Bldg. Ste. 1100

Fort

Sept. 1, 1968

13568

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21d Film 406 Maryland State Department of Health  
11-4-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13564

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13576

1. DECEASED NAME (Type or Print) <b>EUGENE VANCE HERBAUGH</b>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>Sept. 9, 1968</b>			2b. HOUR OF DEATH <b>4:10 P.M.</b>			
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>10/11/1931</b>	6. AGE (In years last birthday) <b>36</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year <b>Sept. 9, 1968</b>			2d. HOUR <b>5:30 P.M.</b>
7a. BIRTHPLACE (State or foreign country) <b>W.VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b> Md.			
10. CITY OR TOWN OF DEATH <b>HANCOCK</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>R.F.D.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LABORER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>ORCHARD</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>HANCOCK</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>R.F.D.</b>		
14. FATHER'S NAME <b>GRADY</b>			15. MOTHER'S MAIDEN NAME <b>X HERBAUGH ELIZABETH ARNOLD</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>KOREA 236 50 2444</b>		17. INFORMANT ADDRESS <b>EVELYN HERBAUGH RURAL 2, HANCOCK, MD.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pending Multiple cutaneous contusions and Abrasions</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>9/12/1</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>4:10 P.M. 9-9- 19 68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Pinned beneath over turned farm tractor.</b>				
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Fruit Farm</b>			21f. LOCATION Street or R.F.D. No. City or Town County State <b>R.F.D. Hancock, Washington, Md.</b>				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Dr. E. W. Ditto, Jr.</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>Sept. 10, 1968</b>			
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>			215 W. Washington St., Hagerstown, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>9/12/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BLACK OAK MENONITE RURAL WARFORDSBURG FULTON PA.</b>			23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Richard J. Shove</b>			ADDRESS <b>Hancock, Md.</b>			25a. REC'D BY REGISTRAR <b>SEP 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

25281

9614629

YAHV

143809

MALE WHITE NOVEMBER 26

WASHINGTON

C.A.2.U

• 45 •

GRANDS.

LABOR

• • • • •

HAGOOD

• • • • • X

XOCCYAN

VICTORINE AW

2308

473851-13

4004631 X

YDASO

JALUF

28/5/98

BLACK OAK MEMORIAL BURIAL WARDENBURG

1981 8 19 32

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-14  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13565

CERTIFICATE OF DEATH

13577

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR AM PM	
MARY JULIA HERSHEY						September 24 1968			10.5	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		White		November 1 1876			91 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH	
Virginia			USA						Washington Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Wash County Hospital			Housewife			Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			Washington Hagerstown			YES			245 West Side Ave	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Jacob Brumbach			Amanda Copp							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address				
No			N one			Clarence A. Hershey 314 Cherry Tree Circle				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4109 Acute pulmonary edema									4 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									2 days	
arteriosclerotic heart disease									yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
4201 advanced age										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
none			-							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			none 19			none				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
			none							
22a. I certify that (I) (this hospital) attended the deceased from Aug 1961, to Sept 24, 1968, that (I) (we) last saw the deceased alive on Sept. 24 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED	
Harold R. Tritch MD									9-24-68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
Dr. Harold R. Tritch, Jr MD						302 N. Potomac Street Hagerstown Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial			9/27/68			Rose Hill Cemetery			Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
Andrew K. Coffman Funeral Home Inc						DATE SEP 27 1968			Charles Judge	

MEDICAL CERTIFICATION



257-4932

1905-1906

13566

## CERTIFICATE OF DEATH

13578

1. DECEASED-NAME (Type or print) <b>ETHEL</b>			First <b>ELIZABERTH</b>			Middle <b>HOSE</b>			Last			2a. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>21</b> Year <b>68</b>			2b. HOUR <b>2:25am</b>			
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>NOVEMBER 30, 1904</b>			6. AGE (In years last birthday) <b>63</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>			IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>			
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>WASHINGTON</b> Md.									
1d. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON COUNTY HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>BEAUTICIAN</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>BEAUTY SHOP</b>									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>WASHINGTON</b>			13c. CITY OR TOWN <b>HAGERSTOWN</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>406 W. WASHINGTON ST.</b>						
14. FATHER'S NAME First <b>HARVEY</b> Middle <b>E</b> Last <b>BEATTY</b>			15. MOTHER'S MAIDEN NAME First <b>LOLA</b> Middle <b>MARY</b> Last <b>ELKINS</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>215-30-9507</b>			17. INFORMANT Address <b>MRS. ETHEL B. EVERHART, HAGERSTOWN, MD.</b>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>431.0</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive cardiovascular dis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>331.X Diabetes Mellitus</b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>years</b> <b>years</b>			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b> P.M. <b></b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>												
22a. I certify that (I) (this hospital) attended the deceased from <b></b> , 19 <b></b> , to <b></b> , 19 <b></b> , that (I) (we) lost saw the deceased alive on <b></b> , 19 <b></b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <b>Sidney Novenstein</b>			DEGREE <b></b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>9/23/68</b>									
22d. PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN, M.D.</b>			22e. ADDRESS <b>FUNKSTOWN, MARYLAND</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>9/24/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASHINGTON, MD.</b>									
24. FUNERAL DIRECTOR <b>Charles M. Rager</b>			ADDRESS <b>HAGERSTOWN, MARYLAND</b>			25a. REC'D BY REGISTRAR <b>SEP 24 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1328

67-37-4

10

Wm. J. F. Jones

8291 45432

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a film 360  
10-29-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13567

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13579

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Edith Merle Howell						Month Day Year			1968 11 30		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	White	Nov. 9 1912	55 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year			1968 11 30
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH					
Maryland		U.S.A.		WIDOWED		DIVORCED		Washington Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Pinesburg			Williamsport RFD #2			Housewife			Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Washington			Pinesburg			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Williamsport RFD #2			First Middle Last			First Middle Last					
			Jacob Wesley Teach			Emma Jane Smith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			None			Mrs. May Rook Williamsport			21 N. Vermont St. Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										immed	
IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										uncer.	
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4201											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
CAUSE OF DEATH				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Edward W. Ditto III M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county) 217 W. Washington St. Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)	
Burial				Sept. 7-68		Riverview Cemetery				Williamsport Md.	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR					
Albert L. Leaf Williamsport, Md.						DATE SEP 9 1968					
						25b. REGISTRAR'S SIGNATURE Charles Judge					

10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Mary Odell Huffer						September 28, 1968		5:30 P M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		
Female		White		May 9, 1903		85 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Boonsboro, Md.		U. S. A.				Washington Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington Co., Hospital			Housewife		Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Washington		Boonsboro		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		141 Lakin Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Harry E. Itnyre			Emma L. Kauffman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No.			220-16-3647		Mr. Roy M. Huffer, 141 Lakin Ave. Boonsboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Myocardial Infarction									1 hour	
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201									2 yrs	
(b) Atherosclerotic Heart Disease										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Rheumatic Heart Disease Congestive Heart Failure										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from April 5, 1967, to Sept 28, 1968, that (I) (we) last saw the deceased alive on Sept 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
Edison B. Moody								9/30/68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
Edson B. Moody, M.D.				363 S. Cleveland Ave. Hagerstown, Md.						
23a. BURIAL, CREMATION, REINTERMENT		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Buried		10-1-68		Boonsboro Cemetery		Boonsboro, Wash. Co., Md.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				OCT 3 1968		Charles Judge				

11580  
 11581  
 11582  
 11583  
 11584  
 11585  
 11586  
 11587  
 11588  
 11589  
 11590  
 11591  
 11592  
 11593  
 11594  
 11595  
 11596  
 11597  
 11598  
 11599  
 11600  
 11601  
 11602  
 11603  
 11604  
 11605  
 11606  
 11607  
 11608  
 11609  
 11610  
 11611  
 11612  
 11613  
 11614  
 11615  
 11616  
 11617  
 11618  
 11619  
 11620  
 11621  
 11622  
 11623  
 11624  
 11625  
 11626  
 11627  
 11628  
 11629  
 11630  
 11631  
 11632  
 11633  
 11634  
 11635  
 11636  
 11637  
 11638  
 11639  
 11640  
 11641  
 11642  
 11643  
 11644  
 11645  
 11646  
 11647  
 11648  
 11649  
 11650  
 11651  
 11652  
 11653  
 11654  
 11655  
 11656  
 11657  
 11658  
 11659  
 11660  
 11661  
 11662  
 11663  
 11664  
 11665  
 11666  
 11667  
 11668  
 11669  
 11670  
 11671  
 11672  
 11673  
 11674  
 11675  
 11676  
 11677  
 11678  
 11679  
 11680  
 11681  
 11682  
 11683  
 11684  
 11685  
 11686  
 11687  
 11688  
 11689  
 11690  
 11691  
 11692  
 11693  
 11694  
 11695  
 11696  
 11697  
 11698  
 11699  
 11700  
 11701  
 11702  
 11703  
 11704  
 11705  
 11706  
 11707  
 11708  
 11709  
 11710  
 11711  
 11712  
 11713  
 11714  
 11715  
 11716  
 11717  
 11718  
 11719  
 11720  
 11721  
 11722  
 11723  
 11724  
 11725  
 11726  
 11727  
 11728  
 11729  
 11730  
 11731  
 11732  
 11733  
 11734  
 11735  
 11736  
 11737  
 11738  
 11739  
 11740  
 11741  
 11742  
 11743  
 11744  
 11745  
 11746  
 11747  
 11748  
 11749  
 11750  
 11751  
 11752  
 11753  
 11754  
 11755  
 11756  
 11757  
 11758  
 11759  
 11760  
 11761  
 11762  
 11763  
 11764  
 11765  
 11766  
 11767  
 11768  
 11769  
 11770  
 11771  
 11772  
 11773  
 11774  
 11775  
 11776  
 11777  
 11778  
 11779  
 11780  
 11781  
 11782  
 11783  
 11784  
 11785  
 11786  
 11787  
 11788  
 11789  
 11790  
 11791  
 11792  
 11793  
 11794  
 11795  
 11796  
 11797  
 11798  
 11799  
 11800  
 11801  
 11802  
 11803  
 11804  
 11805  
 11806  
 11807  
 11808  
 11809  
 11810  
 11811  
 11812  
 11813  
 11814  
 11815  
 11816  
 11817  
 11818  
 11819  
 11820  
 11821  
 11822  
 11823  
 11824  
 11825  
 11826  
 11827  
 11828  
 11829  
 11830  
 11831  
 11832  
 11833  
 11834  
 11835  
 11836  
 11837  
 11838  
 11839  
 11840  
 11841  
 11842  
 11843  
 11844  
 11845  
 11846  
 11847  
 11848  
 11849  
 11850  
 11851  
 11852  
 11853  
 11854  
 11855  
 11856  
 11857  
 11858  
 11859  
 11860  
 11861  
 11862  
 11863  
 11864  
 11865  
 11866  
 11867  
 11868  
 11869  
 11870  
 11871  
 11872  
 11873  
 11874  
 11875  
 11876  
 11877  
 11878  
 11879  
 11880  
 11881  
 11882  
 11883  
 11884  
 11885  
 11886  
 11887  
 11888  
 11889  
 11890  
 11891  
 11892  
 11893  
 11894  
 11895  
 11896  
 11897  
 11898  
 11899  
 11900  
 11901  
 11902  
 11903  
 11904  
 11905  
 11906  
 11907  
 11908  
 11909  
 11910  
 11911  
 11912  
 11913  
 11914  
 11915  
 11916  
 11917  
 11918  
 11919  
 11920  
 11921  
 11922  
 11923  
 11924  
 11925  
 11926  
 11927  
 11928  
 11929  
 11930  
 11931  
 11932  
 11933  
 11934  
 11935  
 11936  
 11937  
 11938  
 11939  
 11940  
 11941  
 11942  
 11943  
 11944  
 11945  
 11946  
 11947  
 11948  
 11949  
 11950  
 11951  
 11952  
 11953  
 11954  
 11955  
 11956  
 11957  
 11958  
 11959  
 11960  
 11961  
 11962  
 11963  
 11964  
 11965  
 11966  
 11967  
 11968  
 11969  
 11970  
 11971  
 11972  
 11973  
 11974  
 11975  
 11976  
 11977  
 11978  
 11979  
 11980  
 11981  
 11982  
 11983  
 11984  
 11985  
 11986  
 11987  
 11988  
 11989  
 11990  
 11991  
 11992  
 11993  
 11994  
 11995  
 11996  
 11997  
 11998  
 11999  
 12000

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parenthesis in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13569

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13581

## Item#14 Film#G404 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last <b>SUSAN ELIZABETH JACKSON</b>			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>9 15 1968</b>			2b. HOUR <b>6:25 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Sept. 8, 1954</b>	6. AGE (In years last birthday) <b>14</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS <b>9 15</b>	IF UNDER 24 HRS. HOURS MIN. <b>15 6:25</b>	2c. DATE PRONOUNCED DEAD Month Day Year <b>9 15 1968</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Co. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Near Fred.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last <b>Ernest Kurstz Jackson</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Anna Mercer</b>			13e. STREET AND NUMBER <b>Route # 1 Harmony Grove</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. <b>218-50-3391</b>		17. INFORMANT ADDRESS <b>Mr. Ernest K. Jackson Route # 1 Frederick, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration gastric contents and</b> <b>818.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture occipital area (hept) &amp; laceration</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>right frontal &amp; temporal lobes</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Approx. 36 hrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>8244</b>							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>9-13 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Fall from truck onto roadway</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Rural Road</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>Utzie Mills Rd Frederick Fred. Md</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Edward W. Ditto, III</b> EXAMINER'S NAME (Type) <b>217 W. WASHINGTON ST. HAG. MD.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>9-15-68</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-17-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Frederick, Frederick, Md.</b>	
24. FUNERAL DIRECTOR <b>Robert E. Dailey &amp; Son</b>				ADDRESS <b>Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>SEP-18 1968</b>	
						25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

January 1, 1964

Dear Sir:

Reference is made to your letter of December 15, 1963.

Enclosed for you are two copies of a letterhead memorandum.

Very truly yours,

John Edgar Hoover

JOHN EDGAR HOOVER  
DIRECTOR

Enclosure

Very truly yours,  
John Edgar Hoover  
Director

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First EDITH			Middle ADALAD			Last JENNINGS		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 4/1/1883			20. DATE OF DEATH SEPTEMBER 12 <sup>day</sup> Year 1968 <sup>10<sup>AM</sup></sup>		
70. BIRTHPLACE (State or foreign country) INDIANA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH WASHINGTON Md.		
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give Address) AVALON MANOR HOME			12a. USUAL OCCUPATION (Kind of work done during life, or if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND			13b. COUNTY WASHINGTON			13c. CITY OR TOWN HAGERSTOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First GEORGE			Middle HAM			15. MOTHER'S MAIDEN NAME First UNKNOWN			Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 219-12-2230B			17. INFORMANT MR. JACK JENNINGS			Address HAGERSTOWN MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 433.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>332X</u> (b) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertensive cardiac dis.; Chronic brain syndrome</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 wks</u> <u>year</u> <u>year</u>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>around 12, 1963</u> , to <u>Sept 8, 1968</u> , that (I) (we) lost saw the deceased alive on <u>8 Sept 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Richard T. Binford</u> 22c. PHYSICIAN'S NAME (Type) Richard T. Binford									22d. DATE SIGNED 12 Sept 68		
22e. ADDRESS <u>Hagerstown, Md.</u>									22f. ADDRESS		
23a. BURIAL CREMATION <u>BURIAL</u>			23b. DATE 9/15/68			23c. NAME OF CEMETERY OR CREMATORY CROWN POINT CEM.			23d. LOCATION (City or Town) (County) (State) KOKOMO HOWARD IND.		
24. FUNERAL DIRECTOR <u>W. T. Norman Hagerstown, Md.</u>						25a. REC'D BY REGISTRAR DATE SEP 17 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



10001

UNITED STATES DEPARTMENT OF THE ARMY

OFFICE OF THE CHIEF OF MEDICAL SERVICE

10001

REPORT OF MEDICAL EXAMINATION

NAME: [REDACTED] GRADE: [REDACTED]

REGIMENT: [REDACTED] COMPANY: [REDACTED]

DATE OF EXAMINATION: [REDACTED]

PLACE OF EXAMINATION: [REDACTED]

REPORT MADE BY: [REDACTED]

REPORT MADE AT: [REDACTED]

REPORT MADE FOR: [REDACTED]

REPORT MADE BY: [REDACTED]

REPORT MADE AT: [REDACTED]

REPORT MADE FOR: [REDACTED]

REPORT MADE BY: [REDACTED]

REPORT MADE AT: [REDACTED]

REPORT MADE FOR: [REDACTED]

REPORT MADE BY: [REDACTED]

REPORT MADE AT: [REDACTED]

REPORT MADE FOR: [REDACTED]

REPORT MADE BY: [REDACTED]

REPORT MADE AT: [REDACTED]

REPORT MADE FOR: [REDACTED]

REPORT MADE BY: [REDACTED]

REPORT MADE AT: [REDACTED]

REPORT MADE FOR: [REDACTED]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>13571</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>13583</span> </div> <div style="text-align: center; margin-top: 5px;"> <b>CERTIFICATE OF DEATH</b> </div>																										
1. DECEASED-NAME (Type or print)			First <b>Enever</b>			Middle <b>Wright</b>			Last <b>Jones</b>			2a. DATE OF DEATH Sept. Month 17 Day 1968			2b. HOUR 10:10 A.M.											
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>7/18/15</b>			6. AGE (In years last birthday) <b>53</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.											
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH <b>WASHINGTON</b>			Md.														
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Salesman</b>			12b. KIND OF BUSINESS OR INDUSTRY																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince George</b>			13c. CITY OR TOWN <b>Hyattsville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>4209 Farragut St.</b>														
14. FATHER'S NAME			First <b>Rossie</b>			Middle <b>Wright</b>			Last <b>Jones</b>			15. MOTHER'S MAIDEN NAME			First <b>Lillie</b>			Middle <b>Mae</b>			Last <b>Watfield</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>245-03-0460</b>			17. INFORMANT <b>Lillie Mae Watfield</b>			Address																	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART 1. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Lobular pneumonia, bilateral, lower lobes</b> <b>4379</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ <b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b> <b>334 X</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>														
												<b>2 Yrs.-8 mos</b>														
MEDICAL CERTIFICATION															19a. DATE OF OPERATION <b>9/5/68</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Flexion contractures, left leg</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		
															21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
															21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
															22a. I certify that (I) (the hospital) attended the deceased from <b>April 15, 1968</b> , to <b>Sept. 17, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept. 17, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22d. PHYSICIAN'S NAME (Type) <b>Domingo A. Garcia, M.D.</b>			22e. ADDRESS <b>Western Md. State Hospital 1500 Pennsylvania Ave., Hagerstown, Md.</b>																							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			23b. DATE <b>9/17/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Maplewood Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Wilson, Wilson N.C.</b>																	
24. FUNERAL DIRECTOR <b>Chm Ronger</b>			ADDRESS <b>Hagerstown Md.</b>			25a. REC'D BY REGISTRAR DATE <b>SEP 24 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>																	

13583

Sept. 17 1968

James

White

James

James

James

James

James

James

James

James

James

James

James

James

James

James

James



SEP 1 1968

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Early delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>13572</div> <div>13584</div>									
<div>1. DECEASED-NAME (Type or Print)</div> <div>First Middle Last</div> <div>Bennett Eugene Kauffman Jr.</div>									
<div>3. SEX</div> <div>Male</div>		<div>4. RACE</div> <div>White</div>		<div>5. DATE OF BIRTH</div> <div>7/2/1965</div>		<div>6. AGE (In years last birthday)</div> <div>3 YRS.</div>		<div>20. DATE KNOWN OF DEATH</div> <div>Month Day Year</div> <div>9 28 1968</div>	
<div>70. BIRTHPLACE (State or foreign country)</div> <div>Penna.</div>		<div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>		<div>B. MARRIED</div> <div>NEVER MARRIED</div> <div>WIDOWED</div> <div>DIVORCED</div>		<div>9. COUNTY OF DEATH</div> <div>Washington</div>		<div>2c. DATE PRONOUNCED DEAD</div> <div>Month Day Year</div> <div>9 28 1968</div>	
<div>10. CITY OR TOWN OF DEATH</div> <div>Hagerstown Md.</div>			<div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>Washington Co. Hospital</div>			<div>120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</div> <div>Child</div>		<div>12b. KIND OF BUSINESS OR INDUSTRY</div> <div>X</div>	
<div>130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>Pa.</div>			<div>13b. COUNTY</div> <div>Franklin</div>			<div>13c. CITY OR TOWN</div> <div>Greencastle</div>		<div>13e. STREET AND NUMBER</div> <div>R.R.#3</div>	
<div>14. FATHER'S NAME</div> <div>First Middle Last</div> <div>Bennett Eugene Kauffman Sr.</div>					<div>15. MOTHER'S MAIDEN NAME</div> <div>First Middle Last</div> <div>JoAnn Shearer</div>				
<div>160. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>X</div>			<div>16b. SOCIAL SECURITY NO.</div> <div>X</div>		<div>17. INFORMANT</div> <div>Mrs. Catherine Shearer</div>				
<div>16a. ADDRESS</div> <div>754 L.W. East Chambersburg Penna.</div>									
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) Massive Hemorrhage &amp; shock due to laceration liver &amp; rupture of spleen</div> <div>819.9</div> <div>DOE TO, OR AS A CONSEQUENCE OF</div> <div>(b) erosion liver &amp; rupture of spleen</div> <div>DOE TO, OR AS A CONSEQUENCE OF</div> <div>(c) Pulmonary Edema &amp; Bilateral Atherosclerosis</div> <div>8254</div> <div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)</div>									
<div>19a. DATE OF OPERATION</div> <div>9-28-68</div>			<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</div> <div>Control Bleeding from Laceration Liver</div>				<div>20. AUTOPSY?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>		
<div>210. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/></div> <div>CAUSE OF DEATH</div>			<div>21b. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>9-27 1968</div>		<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div> <div>Injury in Auto Accident</div>				
<div>21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input checked="" type="checkbox"/></div>		<div>21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</div> <div>Main Highway</div>		<div>21f. LOCATION</div> <div>Street or R.F.D. No.</div> <div>City or Town</div> <div>County</div> <div>State</div> <div>Rt #11, 2 Mi. S. Greencastle Franklin Pa.</div>					
<div>22a. I certify that I took charge of the remains described above, held on</div> <div>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</div> <div>Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div>									
<div>ACTUAL SIGNATURE</div> <div>DR. E.W. DITTO, III</div> <div>EXAMINER'S NAME (Type)</div> <div>217 W. WASHINGTON ST.</div>					<div>CHIEF MEDICAL EXAMINER</div> <div>ASSISTANT MEDICAL EXAMINER</div> <div>DEPUTY MEDICAL EXAMINER</div> <div>ADDRESS (Street, city, town, or county)</div>				
<div>230. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>		<div>23b. DATE</div> <div>10/1/1968</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Corpus Christi Cemetery</div>		<div>23d. LOCATION (City or Town) (County) (State)</div> <div>Chambersburg-Franklin-Penna.</div>			
<div>24. FUNERAL DIRECTOR</div> <div>ADDRESS</div> <div>Robert G. Sellers, -- Chambersburg Pa. 17201</div>					<div>250. REC'D BY REGISTRAR</div> <div>DATE</div> <div>OCT 3 1968</div>		<div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>		

FILE, OFFICE, N.E. . 90  
WOTD/H2A . 4/1/53

8921 7 • T30



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13585

13573

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Lawrence Edward Kendall</b>			2a. DATE OF DEATH <b>9</b> Month <b>24</b> Day <b>68</b> Year			2b. HOUR <b>M</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>May 17, 1911</b>		6. AGE (In years last birthday) <b>57</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>102 E. First St.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Wash.</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
13e. STREET AND NUMBER <b>102 E. First St.</b>							
14. FATHER'S NAME First Middle Last <b>Charles Edgar Kendall</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>N. Pearl Micheal</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-09-2603</b>		17. INFORMANT Address <b>Mamie Kendall Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Hrs.</b> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. <b>4109</b> (b) <b>Arteriosclerotic Heart Disease</b> Not known DUE TO, OR AS A CONSEQUENCE OF, (c) <b>Arteriosclerosis, General</b> Not known PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>Diabetes Mellitus</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>9-13-68</b> to <b>9-24-68</b> , that (I) (we) last saw the deceased alive on <b>9-13-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Arturo Riego</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9-25-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Arturo Riego</b>		22e. ADDRESS <b>119 E. Antietam St. Hagerstown</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>9-27-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Minnich Funeral Home Hagerstown, Md</b>				25a. REC'D BY REGISTRAR <b>SEP 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

RECEIVED OF

James Edward Kendal

Nov 17, 1911

Washington

103 E. 27th St. New York

103 E. 27th St. New York

Charles Edward Kendal

215-37-2500 James Kendal

Printed Matter  
Patent Office  
Patent Office  
Patent Office

James Kendal  
119 E. 27th St. New York

2-27-08

James Kendal

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13574										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13586									
CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print)					First <b>Mary</b>					Middle <b>Ida</b>					Last <b>Kershner</b>					2a. DATE OF DEATH <b>Sept. 24</b>					2b. HOUR <b>11 P.M.</b>				
3. SEX <b>Female</b>					4. RACE <b>White</b>					5. DATE OF BIRTH <b>August 28, 1897</b>					6. AGE (In years last birthday) <b>71</b> YRS.					IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>28</b>					IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>				
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>					7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>Washington</b> Md.														
10. CITY OR TOWN OF DEATH <b>Rural Hagerstown</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Avalon Manor Nursing Home</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Clerical Work Maryland Ribbon Co</b>					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>					13b. COUNTY <b>Washington</b>					13c. CITY OR TOWN <b>Hagerstown</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <b>252 Hager Street</b>									
14. FATHER'S NAME First <b>Millard</b>					Middle <b>Filmere</b>					Last <b>Kershner</b>					15. MOTHER'S MAIDEN NAME First <b>Susan</b>					Middle <b></b>					Last <b>Rowe</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>					16b. SOCIAL SECURITY NO. <b>214-09-6734</b>					17. INFORMANT <b>Miss Susan Kershner Hagerstown, Maryland</b>										252 Hager Street									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b> <b>157.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 mo.</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>157X</b>																													
19a. DATE OF OPERATION <b>157X</b>					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 25</b> , 19 <b>68</b> , to <b>SEPT. 24</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>SEPT. 24</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <b>Lloyd A. Hoffner</b>															DEGREE <b></b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>9/25/68</b>				
22d. PHYSICIAN NAME (Type) <b>Lloyd A. Hoffner</b>															22e. ADDRESS <b>214 N. Potomac St. Hagerstown, Md.</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE <b>Sept. 27, 1968</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>					23d. LOCATION (City or Town) (County) (State) <b>Williamsport, Washington, Md.</b>														
24. FUNERAL DIRECTOR <b>Albert L. Leaf</b>															ADDRESS <b>Williamsport, Maryland.</b>					25a. REC'D BY REGISTRAR DATE <b>SEP 30 1968</b>					25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

13586

RECEIVED

1965

1965

1965

1965

M

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13583  
13575  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>3 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Clear Spring</b> d. STREET ADDRESS <b>RFD-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Dallas Hamilton Krontz</b>				4. DATE OF DEATH Month Day Year <b>Sept. 17, 1968</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 22, 1883</b> 9. AGE (in years last birthday) <b>85 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John P. Krontz</b>				14. MOTHER'S MAIDEN NAME <b>Dottie A. Mills</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-05-9900</b>		17. INFORMANT <b>Mrs Elsie V. Krontz</b>		Address <b>RFD-2 C. Spring</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute gastro-enteritis</b> <b>561X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5711</b> (b) <b>Unknown cause</b> DUE TO (c) <b>5711</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Two Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive -cardiovascular disease, gastric ulcer, atherosclerosis; Cerebral &amp; Generalized</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 16, 1968</b> , to <b>Sept. 17, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept. 17, 1968</b> , and that death occurred at <b>11:35am</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William T. Layman, M.D.</b>				22b. DATE SIGNED <b>September 19, 1968</b>		22c. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>	
22d. ADDRESS <b>100 Professional Arts Bldg, Hagerstown</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 20, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		23d. LOCATION (City, town or county) (State) <b>Clear Spring, Maryland</b>	
24. FUNERAL DIRECTOR <b>Thompson Funeral Home</b>				25a. REC'D BY REGISTRAR <b>SEP 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



M

Washington

Harrodsburg

3 Days

Clear Spring

Washington

Maryland

Washington County Hospital

RFD-2

Dallas

Hamilton

Krontz

Sept. 17,

08

X

White

Male

March 22, 1983 82

Ballinroad

Washington Co. Md.

U.S.A.

John P. Krontz

Dottie A. Mills

219-05-9900 Mrs. Elate V. Krontz

RFD-2 C. Spring

No

Acute gastro-enteritis

Two days

Unknown cause

Cardiovascular disease, gastric ulcer, atherosclerosis, generalized

Sept. 17

Sept. 17

Sept. 17

*William T. Lavenex, M.D.*

William T. Lavenex, M.D.

100 Professional Ave. High, Harrodsburg, Ky. 40330

Sept. 20, 88 Rose Hill

Clear Spring, Maryland

Thompson Funeral Home Clear Spring, Md. 21768

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last <b>Molly Viola Lehman</b>					2a. DATE OF DEATH 9 Month 23 Day 68 Year			2b. HOUR 10a M		
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Dec. 11, 1881</b>		6. AGE (In years last birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.				
10. CITY OR TOWN OF DEATH <b>Williamsport</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Williamsport Sanitarium</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Wash.</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>123 Broadway</b>	
14. FATHER'S NAME First Middle Last <b>Samuel Moats</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Anne Munson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Ruth Schreck Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b> (b) <b>Arteriosclerosis - Generalized</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Hypertensive Vascular Disease</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>10 yrs.</b> <b>8 yrs.</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 4, 1954</b> to <b>Sept. 23, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept. 10, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Clay A. Hoffman</b> DEGREE. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>9/25/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Clay A. Hoffman</b>						22e. ADDRESS <b>214 N. Potomac St. Hagerstown</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-26-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Minnich Funeral Home Hagerstown, Md.</b>					25a. REC'D BY REGISTRAR <b>SEP 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

1888

RECORDS OF DEATH

1888 23 28 1888

Dec. 11, 1881

Washington

William H. Harrison

123 Broadway

London

1888

1888

1888

1888

1888

1888

1888

SEP 14 1888

1888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13577

13589

1. DECEASED-NAME (Type or print) <b>Earl Dean Long</b>			2a. DATE OF DEATH Month <b>September</b> Day <b>20</b> Year <b>1968</b>			2b. HOUR <b>M</b>				
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>April 28, 1920</b>		6. AGE (In years last birthday) <b>48</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Co. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>caretaker</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Penna.</b>			13b. COUNTY <b>Fulton</b>			13c. CITY OR TOWN <b>McConnellsburg</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>RFD 1</b>			14. FATHER'S NAME First <b>Earl L.</b> Middle <b>Long</b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>Lydia S.</b> Middle <b>Hess</b> Last <b></b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>yes</b> (If yes give year or dates of service) <b>WW II</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT Address <b>Daryl Long, McConnellsburg, Penna.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> <b>450X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>465X Spontaneous increased intracranial pressure (pseudo-tumor)</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b> P.M. <b></b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>9/6</b> , 19 <b>68</b> , to <b>9/20</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>9/20</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>A.F. Abdulla</b> M.D. DEGREE						22c. DATE SIGNED <b>9/21/68</b>			22d. PHYSICIAN'S NAME (Type) <b>A.F. Abdulla</b>	
22e. ADDRESS <b>318 N. Potomac, Hagerstown, Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>9-23-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Knobsville Meth. Cem.</b>			23d. LOCATION (City or Town) <b>Todd Township, Penna.</b> (County) <b></b> (State) <b></b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>SEP 24 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION

13589

INVOICE OF GOODS

13589

September 30, 1900

Long

Long

Long

April 20, 1900

White

White

Washington

Long

Long

Washington

Health Co. Hospital

Washington

Washington, D.C.

Long

Long

April 20, 1900

April 20, 1900

April 20, 1900, Washington, D.C.

1900

April 20, 1900

Washington, D.C.

Washington, D.C. 1900

1900-00

Washington, D.C. 1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13578										13590														
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
Lewis Ray McCoy										September 3, 1968					11:15A M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.									
Male			White			Oct. 12, 1896			71			MONTHS DAYS			HOURS MIN.									
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH									
Funkstown, Md.					U. S. A.										Washington Md.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY									
Hagerstown					Washington Co. Hospital					Printer					Printing									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER				
Maryland					Washington					Funkstown					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					18 Poplar St.				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
Lewis Clinton McCoy					Margaret Jacobs																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address									
No.					214-09-2392					Mr. L. Raymond McCoy, 309 E. Wilson Blvd.					Hagerstown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>															3-4 DAYS									
4129 DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																								
(b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>															YEARS									
DUE TO, OR AS A CONSEQUENCE OF																								
(c)																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
4200																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <u>5 April</u> , 19 <u>66</u> , to <u>3 Sept.</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3 Sept.</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE															22c. DATE SIGNED									
<u>W. N. FENDER</u>															4 Sept. 1968									
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS									
W. N. FENDER															218 N. POTOMAC ST., HAGERSTOWN, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					9- 6- 68					Funkstown Cemetery					Funkstown, Wash. Co., Md.									
24. FUNERAL DIRECTOR ADDRESS															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
John H. Bagt, Jr. 112 N. Main St., Boonsboro, Md.															SEP 6 1968					Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First VICTOR		Middle GROVE		Last MC GRAW		2a. DATE OF DEATH Month Day Year Sept. 3 1968		2b. HOUR 5 PM
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 13 1905		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS 6 20		IF UNDER 24 HRS. HOURS MIN. 12 5
7a. BIRTHPLACE (State or foreign country) Sharpsburg Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington		Md.		
10. CITY OR TOWN OF DEATH Sharpsburg Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 102 W. Antietam St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sheet Metal Worker		12b. KIND OF BUSINESS OR INDUSTRY Dixie Narco		Co		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Sharpsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 102 W Antietam St.		
14. FATHER'S NAME First Middle Last F. Webster Mc Graw		15. MOTHER'S MAIDEN NAME First Middle Last Vada E. Grove								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-09-1072		17. INFORMANT Mrs. Glendola Mc Graw		17a. ADDRESS 102 W. Antietam St. Sharpsburg Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>9/1/68</u> , 19 <u>68</u> , to <u>9/3</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9/3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Curran</u>		DEGREE MED. DIRECTOR		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/6/68				
22d. PHYSICIAN'S NAME (Type) R. Amarillo		22e. ADDRESS Sharpsburg, Md 21782								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 6-68		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City or Town) (County) (State) Sharpsburg Washington Md.				
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Md.		ADDRESS		25a. REC'D BY REGISTRAR DA SEP 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

13521

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13580  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13592

1. DECEASED-NAME (Type or print) <b>ALICE OLIVIA McKEE</b>			2a. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>30</b> Year <b>68</b>			2b. HOUR <b>1 p m</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MARCH 3, 1878</b>		6. AGE (In years last birthday) <b>90</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b> Md.	
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>JACKSON CONVALESCANT HOME</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>NONE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>HAGERSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>WILLIAM C McKEE</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>EMMA K MIDDLEKAUFF</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. LAURA CROSSON</b>		50 Address <b>HILLCREST RD. HAGERSTOWN, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4301</b> (b) <b>Arteriosclerosis - Generalized</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>10 yrs.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>senility</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) <del>did not</del> attended the deceased from <b>Jan.</b> , 1960, to <b>SEPT. 30</b> , 1968, that (I) <del>did not</del> last saw the deceased alive on <b>SEPT 11</b> , 1968, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did not</del> (did not) view the body after death.							
22b. SIGNATURE <b>Lloyd A. Hoffman</b> DEGREE <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>10/1/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>LLOYD A HOFFMAN, M.D.</b>				22e. ADDRESS <b>214 N POTOMAC ST., HAGERSTOWN, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10/3/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSEHILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN, WASHINGTON, MD.</b>	
24. FUNERAL DIRECTOR <b>Charles M. Rouse</b>		ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>OCT 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

DATE: 10/10/68

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK (100-100000)

SUBJECT: JAMES EARL RAY; AKA; ALIASES; ET AL.

RE: NEW YORK TELETYPE TO BUREAU, 10/9/68.

FOR INFORMATION OF THE BUREAU, THE FOLLOWING IS A SUMMARY OF THE INFORMATION RECEIVED FROM THE NEW YORK OFFICE:

ON 10/9/68, THE NEW YORK OFFICE RECEIVED A TELEPHONE CALL FROM AN INDIVIDUAL WHO IDENTIFIED HIMSELF AS JAMES EARL RAY.

THE INDIVIDUAL STATED THAT HE WAS CURRENTLY IN NEW YORK CITY AND WAS SEEKING EMPLOYMENT.

HE STATED THAT HE HAD BEEN CONVICTED OF A CRIME IN MISSISSIPPI AND WAS CURRENTLY ON PAROLE.

HE STATED THAT HE HAD BEEN IN CONTACT WITH SEVERAL INDIVIDUALS WHO WERE CURRENTLY IN NEW YORK CITY.

HE STATED THAT HE HAD BEEN ADVISED THAT HE SHOULD CONTACT THE NEW YORK OFFICE OF THE FBI.

THE NEW YORK OFFICE IMMEDIATELY ADVISED THE BUREAU OF THE MATTER.

THE BUREAU IS CURRENTLY REVIEWING THE MATTER AND WILL ADVISE THE NEW YORK OFFICE OF THE RESULTS OF THE REVIEW.

VERY TRULY YOURS,

J. Edgar Hoover, Director

OCT 10 1968

FBI

NEW YORK

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

13581										MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13593				
1										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
GEORGE GREENBERRY MELLOTT										SEPT. 20, 1968					11:30 P.M.									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.									
MALE			WHITE			SEPT. 13, 1903			65 YRS.			MONTHS DAYS HOURS MIN.												
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH															
W.VA.			U.S.A.						WASHINGTON Md.															
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY									
HANCOCK					SENSEL ROAD					SHEET METAL ASSBL. AIRPLANE														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER				
MARYLAND					WASHINGTON					HANCOCK					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					SENSEL ROAD				
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																			
HOWARD S.. MELLOTT					ANNA B. FITTERTY																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address														
NO					220 09 9342					GLADYS L. MELLOTT HANCOCK, MD.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>															5 min									
4109 DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>ASHD</u>															10 yrs									
(b) <u>ASHD</u>																								
DUE TO, OR AS A CONSEQUENCE OF																								
(c)																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
<u>Emphysema</u>																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>July 2</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>July 2</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE <u>F.B. Thomas III MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>															22c. DATE SIGNED <u>9-23-68</u>									
22d. PHYSICIAN'S NAME (Type) <u>Frank B. Thomas III MD</u>															22e. ADDRESS <u>Hancock, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
BURIAL					9/23/68					MAYS CHAPEL CEMETERY					WAERORDSBURG FULTON PA.									
24. FUNERAL DIRECTOR ADDRESS															25a. REC'D BY REGISTRAR DATE					25b. REGISTRAR'S SIGNATURE				
<u>Richard J. Grove Hancock, Md.</u>															SEP 25 1968					<u>Charles Judge</u>				

MEDICAL CERTIFICATION

355

13593

## PLAN

371142

20 8001 .51 .7932

X

. A . E . U

NOTHING IS A

XOCCAH

0000 133122

24 JUL 1964 JAT34 T32H2

## QUALITY PLAN

NOTES ON THE REVISION OF THE 1980S

Q204 132.32

TRAILER . . 2 FRANCH

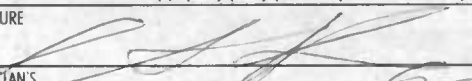
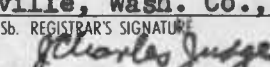
Y 12 T T 13 . 5 AMMA

179

08-09-90 10:00 AM

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

<div style="display: flex; justify-content: space-between;"> <span>13582</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>13594</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div>									
1. DECEASED-NAME (Type or print) <b>Arthur Lee Nokes</b>				2a. DATE OF DEATH Month <b>September</b> Day <b>15</b> Year <b>1968</b>				2b. HOUR <b>1:40A M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 9, 1885</b>		6. AGE (In years last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS <b>7</b> DAYS <b>6</b> IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Point of Rocks, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.			
10. CITY OR TOWN OF DEATH <b>Knoxville Rfd. 2, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Boiler Maker Helper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Knoxville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rfd. 2</b>	
14. FATHER'S NAME First Middle Last <b>James Nokes</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Paralee Corder</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>705-12-0298</b>		17. INFORMANT Address <b>Mr. James Nokes, Knoxville, Rfd. 2, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>4270</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
								<b>3 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4341</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <b>May 8, 1966</b> to <b>Sept. 15, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept. 15, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9-15-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>C. T. Byron Kao, M.D.</b>				22e. ADDRESS <b>Gum Spring Hollow, Brunswick, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-17-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brownsville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Brownsville, Wash. Co., Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>John H. Bast, Jr., 112 N. Main St. Boonsboro, Md.</b>				25a. REC'D BY REGISTRAR <b>SEP 19 1968</b>		25b. REGISTRAR'S SIGNATURE 			

13554

13554

September 12, 1938

Hones

Joe

Print

8

03

Feb. 9, 1938

Wife

Wife

Washington

7

Point of View, Va. U. S. A.

Bolton Hall, Va. Railroad

Knockville, Va. S. M.

W. S.

Knockville

Washington

Maryland

Colon

James

Hones

James

104-12-022 Mr. James Hones, Knockville, Va. S. M.

Mr.

Washington, D. C.

Mr. Hones, 104-12-022

Washington, D. C.

Knockville, Va.

2-1-38

Wife

John L. Bass, Jr., 112 N. Main St., Booneville, Va. 22603



13582

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Margaret Clemma O' Neal</b>			2a. DATE OF DEATH Month <b>September</b> Day <b>17</b> Year <b>1968</b>			2b. HOUR <b>7:10A M</b>								
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 20, 1906</b>		6. AGE (In years lost birthday) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS <b>5</b> DAYS <b>27</b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>				
7a. BIRTHPLACE (State or foreign country) <b>Wash. Co., Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Washington</b> Md.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Co., Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>			13c. CITY OR TOWN <b>Boonsboro</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>7 S. Main St.</b>		
14. FATHER'S NAME First Middle Last <b>Samuel Holmes</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Alberta J. Snyder</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>			16b. SOCIAL SECURITY NO. <b>217- 56- 1665</b>			17. INFORMANT Address <b>Mr. Ralph W. O'Neal, 7 S. Main St. Boonsboro, Md.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardio Vascular disease</b> <b>2509</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yr</b> <b>10 yr</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>260X</b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>May 5</b> , 19 <b>68</b> , to <b>Sept 17</b> , 19 <b>68</b> , that (we) lost the deceased alive on <b>Sept 16</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.														
22b. SIGNATURE <b>A. W. LeVan M.D.</b> DEGREE <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									22c. DATE SIGNED <b>Sept. 18, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>G. W. LeVan M.D.</b>			22e. ADDRESS <b>Boonsboro, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>9- 19- 68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Samples Manor Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Samples Manor Wash. Co. Md.</b>					
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>						25a. REC'D BY REGISTRAR <b>SEP 23 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

John H. Doe, Sr., 112 N. Main St., Boonshoro, Mo. SEP 1 1963  
 Samuel H. Doe, 9-12-58, Boonshoro Manor Cemetery, Boonshoro, Mo.

No. 217-58-1885 Mr. John H. Doe, 112 N. Main St., Boonshoro, Mo.

General Holmes  
 Boonshoro, Mo.  
 112 N. Main St.  
 Boonshoro, Mo.

Boonshoro, Mo.  
 Boonshoro, Mo.  
 Boonshoro, Mo.

Boonshoro, Mo.  
 Boonshoro, Mo.  
 Boonshoro, Mo.

Boonshoro, Mo.  
 Boonshoro, Mo.  
 Boonshoro, Mo.

Boonshoro, Mo.  
 Boonshoro, Mo.  
 Boonshoro, Mo.

Boonshoro, Mo.  
 Boonshoro, Mo.  
 Boonshoro, Mo.

13584

13596

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Clair Isaac Park</b>		First Middle Last		2a. DATE OF DEATH <b>Sept. 27, 1968</b>		Month Day Year		2b. HOUR <b>4:15 A M</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Apr. 12, 1933</b>		6. AGE (In years last birthday) <b>35</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Fulton Co., Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington Co., Md.</b>		Md.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Co. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Letterkenny Ordn. Depot</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Pa.</b>		13b. COUNTY <b>Fulton</b>		13c. CITY OR TOWN <b>Ft. Littleton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Dublin Twp.</b>	
14. FATHER'S NAME <b>Trace</b>		First Middle Last <b>Park</b>		15. MOTHER'S MAIDEN NAME <b>Ethel</b>		First Middle Last <b>Norris</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>Yes Peacetime</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Barbara A. Park, Ft. Littleton, Pa.</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Undifferentiated carcinoma, thyroid with</b> <b>193X</b> DUE TO, OR AS A CONSEQUENCE OF <b>mediastinal &amp; pulmonary metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>194X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 22, 1968</b> , to <b>Sept. 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept. 26, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>J. H. Kehne</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9-27-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>J. H. KEHNE, M. D.</b>		22e. ADDRESS <b>1229 Ravenwood Hts., Hag., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 30, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Grove First Church of God Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Maddensville Huntington Pa.</b>			
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>SEP 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECORDS OF DEATH

1957

1-15

Jan. 1, 1957

Jan. 1, 1957

Jan. 1, 1957

Jan. 1, 1957

Jan. 1, 1957

Jan. 1, 1957

This is a record of the death of a person who was born on Jan. 1, 1957 and died on Jan. 1, 1957.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

13585 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13598			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or Print)			First		Middle		Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Absolum David Peters										Month Day Year		Hour	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male		White		1/28/1879		89 YRS.		MONTHS DAYS		HOURS MIN.		Month Day Year	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH			2d. HOUR	
West Va.			U S A			WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington			1968 7 30 PM	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown				2303 Gay St.								Farmer	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
West Va.						Hampshire Kirby				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		---	
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME			
Harrison								Peters		Kathryn Hott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS	
NO				233-72-5814				Leola Starkey				2303 Gay St Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Bilateral Lobular Pneumonia</u>										2-4 days			
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4129</u>													
(b) <u>Advanced Atherosclerosis Heart</u>										25 yrs			
DUE TO, OR AS A CONSEQUENCE OF													
(c) <u>diarrhea + gas / Atherosclerosis</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
<u>Prostatic hypertrophy Benign</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
				19 P.M.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Edward W. Ditto III, MD</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>EDWARD W. DITTO III MD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
<u>217 W. WASHINGTON ST., HAGERSTOWN, MD.</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
						22b. DATE SIGNED <u>9-1-68</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				9/3/68		Hotts Chapel Cemetery Kirby Hampshire W Va.							
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE	
<u>Wade H. McKee</u>						<u>SEP 13 1968</u>						<u>Charles Judge</u>	



18558

RECEIVED BY MAIL

NEW STATE  
SEP 18 1968

SEP 18 1968

EDWARD W. FITTO III MD  
217 W. WASINGTON ST., ABERSTOWN, MD.

SEP 18 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Bessie			Viola			Pike			Month Day Year September 18, 1968	M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		July 15, 1897		71 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Frederick, Md.			USA				Washington Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington County Hospital			Housewife			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Washington		Hagerstown				918 Corbett St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Eugene			Lenhart			Laura Studebaker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No			214-09-6607		Mrs. Russell F. Hillyard 2214 Cloverleaf Rd. Hagerstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Carcinomatosis</u> <u>180X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Uterus (Cervix)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 yrs</u>										6 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>171X</u> <u>Secondary</u> <u>Carcinoma</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 15, 1964</u> to <u>Sept 18, 1968</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>Sept 18/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>J. H. Berchley</u>										22e. ADDRESS <u>Hagerstown Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) County (State)					
Burial		9/21/68		Rest Haven Cemetery		Hagerstown-Washington-Md.					
24. FUNERAL DIRECTOR <u>Wm. C. Hunt</u>		ADDRESS <u>Rest Haven Funeral Chapel</u>		25a. REC'D BY REGISTRAR <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>SEP 23 1968</u>			

802

1322

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																				
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																				
CERTIFICATE OF DEATH																				
1. DECEASED-NAME (Type or print)			First <b>LELA</b>			Middle <b>RAMONA</b>			Last <b>POFFENBERGER</b>			2a. DATE OF DEATH <b>SEPTEMBER 21</b> Day <b>1968</b>			2b. HOUR <b>9:20</b> AM					
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>2/24/1898</b>			6. AGE (In years last birthday) <b>70</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN					
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>WASHINGTON</b>											
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASH. COUNTY HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND</b>			13b. COUNTY <b>WASHINGTON</b>			13c. CITY OR TOWN <b>HAGERSTOWN</b>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>1137 OAK HILL AVE.</b>								
14. FATHER'S NAME First <b>WYATT</b>			Middle <b>MOATS</b>			Last <b>MOATS</b>			15. MOTHER'S MAIDEN NAME First <b>NETTIE</b>			Middle <b>MAE</b>			Last <b>MOATS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (give war or dates of service) <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>217-42-9015</b>			17. INFORMANT <b>MRS. DOROTHY J. WALLACE</b>			Address <b>HAGERSTOWN MD.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>174x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of breast</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b> <b>10 yrs.</b>																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>170x</b>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 23, 1952</b> , to <b>SEPT 21, 1968</b> , that (I) (we) last saw the deceased alive on <b>SEPT 21, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <b>loyd A. Hoffman</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED <b>9/23/68</b>								
22d. PHYSICIAN'S NAME (Type) <b>LOYD A. HOFFMAN</b>												22e. ADDRESS <b>214 N. Potomac St. Hagerstown, Md.</b>								
23a. BURIAL, CREMATION, <b>BURIAL</b>			23b. DATE <b>9/24/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>			23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASH. MD.</b>											
24. FUNERAL DIRECTOR <b>W. J. Normant, Hagerstown, Md.</b>												25a. REC'D BY REGISTRAR <b>SEP 26 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

13269

OS: €1-200 r

209 18 228/1915

U.S. DEPARTMENT OF COMMERCE

\_\_\_\_\_



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13588

Item #17, Film G405

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13600

1. DECEASED-NAME (Type or Print) <b>Carlton Monroe Purdum Sr.</b>			First Middle Last			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month <b>9</b> Day <b>25</b> Year <b>1968</b>			2b. HOUR <b>3:55 P.M.</b>			
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>4-17-26</b>	6. AGE (In years last birthday) <b>42</b> YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		2c. DATE PRONOUNCED DEAD Month <b>9</b> - Day <b>25</b> - Year <b>1968</b>			2d. HOUR <b>3:55 P.M.</b>	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Washington &amp; York</b>			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Co. Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>Truck Driver</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Netlock</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Fred.</b>			13c. CITY OR TOWN <b>Thurmont</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>Mountaindale</b>
14. FATHER'S NAME <b>Albert M. Purdum</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Mamie Craver</b>			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-30-6320</b>			17. INFORMANT <b>Grace Ida, E. Purdum</b>			Address <b>Thurmont, Md. RD 1</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture Skull - parietal area - 881X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>Massive hemorrhage - Cerebral</b> DUE TO, OR AS A CONSEQUENCE OF <b>Stroke - Med. Brain Hemorrhage and</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>9010 Aspiration Suction Canister</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20hr Approx.</b>	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>7:15 P.M. 9-24-68</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Fell from ladder while painting</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>			21f. LOCATION Street or R.F.D. No. City or Town County State <b>RT #1 Thurmont Fred. Md</b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Edward W. Ditto, III</b>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>9-25-68</b>			
EXAMINER'S NAME (Type) <b>Edward W. Ditto, III, M.D.</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			217 W. Washington St. Hagerstown, Maryland			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>9-29-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Lewistown Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Lewistown Fred. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Raymond E. Creager</b>			ADDRESS <b>Thurmont, Md.</b>			25a. REC'D BY REGISTRAR <b>OCT 1 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

13000

London 1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
FRANKLIN		MAJOR		REED		SEPTEMBER 6		1968		9:20	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		3/13/1911		57 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
WEST VIRGINIA		U.S.A.				WASHINGTON				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
HAGERSTOWN		WASHINGTON COUNTY		CUSTODIAN		SCHOOL					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		WASHINGTON		HAGERSTOWN				915 HAMILTON BLVD.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
First Middle Last		First Middle Last									
WILLIAM		ADISON REED		RETTIE		PRUNTY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
NO		214-09-2265		MRS. HILDA REED		HAGERSTOWN MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary Edema</u>										30 min	
4129 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										1 yr	
(b) <u>Congestive heart failure</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>arteriosclerotic heart disease</u>										yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4200											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>61</u> , to <u>Sept 6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Sept 1</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
<u>Harold R. Tritch Jr</u>		9/7/68		HAROLD R. TRITCH JR		302 N. Potomac St. Hagerstown, Md.					
23a. BURIAL (CREMATION REMOVAL)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		9/9/68		REST HAVEN CEM.		HAGERSTOWN WASH. MD.					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
W. J. Wornment, Hagerstown, Md.		DATE SEP 11 1968		J. Charles Judge							

1364

VE PRACNE

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

• 2004-2005 •

KAT 0019653

2007. 2. 20. 2007. 2. 20.

2000

[illegible]

15

Q110 12/12/10

• (C) *Journal of the American Medical Association*

1871

10  
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 84 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
13590					13602								
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)								
a. COUNTY <b>Washington</b>					a. STATE <b>Maryland</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>					b. COUNTY <b>Washington</b>								
c. LENGTH OF STAY IN 1b <b>27 Days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clear Spring</b>								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>					d. STREET ADDRESS <b>RFD-2</b>								
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year				
<b>Earl</b>			<b>Richard</b>			<b>Repp</b>			<b>Sept. 2, 1968</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 24, 1897</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Wash. Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Adam S. Repp</b>					14. MOTHER'S MAIDEN NAME <b>Rosa Ann Myers</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>220-09-9267</b>		17. INFORMANT <b>Mrs. Annie M. Repp</b>					Address <b>RFD-2 Clear Spring</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Brain Syndrome</b> <b>4409</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, Generalized</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>4500 Pulmonary Emphysema</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>  <b>unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) <del>was present</del> attended the deceased from <b>07/26/68</b> , 19 to <b>09/02/68</b> 19, that (I) <del>last</del> saw the deceased alive on <b>Sept 2, 1968</b> and that death occurred at <b>8:05AM</b> from the causes and on the date stated above.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. SIGNATURE <i>Archie Robert Cohen</i> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>09/04/68</b>					
22c. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>					22d. ADDRESS <b>Clear Spring, Maryland 21722</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Sept. 6, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blairs Valley</b>			23d. LOCATION (City, town or county) (State) <b>Blairs Valley Md.</b>					
24. FUNERAL DIRECTOR <i>Donald E. Thompson</i> <b>Thompson Funeral Home</b>					25a. REC'D BY REGISTRAR <b>SEP 6 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



13802

Washington

Maryland

Washington

Clear Spring

27 Days

Registation

X

RFD-2

Washington County Hospital

68

Sept. 2

Repp

Richard

Earl

Jan. 24, 1997 71

Male white

U.S.A.

Wash. Maryland

Partner

Retired

Rosa Ann Myers

Adam S. Repp

220-09-9267 Mrs. Annie M. Repp RFD-2 Clear Spring

No

Chronic Brain Syndrome

Arteriosclerotic Generalized

Polymyositis

07/24/98  
1:00AM

07/24/98  
Sept 2, 1998

*Robert Cohen*

Clear Spring, Maryland 21722

Arthur Robert Cohen, M.D.

Blair Valley Md.

Blair Valley

Butler

Thompson Funeral Home Clear Spring, Md. 21722

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parenthesis in parenthesis Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

79  
01  
2

2

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<p><b>13591</b> <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> <b>13603</b></p>									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED			
James Edward Robison						<input checked="" type="checkbox"/> Month Day Year <b>Sept. 13, 1968</b>			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD	2b. HOUR
Male	Cau.	5/4/15	53 YRS.					<b>Sept. 13, 1968</b>	<b>6:50 A.M.</b>
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U.S.A.				Washington Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown			Washington Co. Hospital			Operating Engineer			Constr. Wkr.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
Md.			Allegany			Cumberland		YES	117 Oak St.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Thomas E. Robison			Hazel E. McIntosh						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
Yes			W. A. # 2			Mrs. Evelyn C. Robison 117 Oak St. Cumb. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									Several minutes
(b) <b>Chronic Rheumatic Heart Disease, With Mitral Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF									Several years
(c) <b>Cardiac Hypertrophy</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
410x									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			M.D. ASSISTANT MEDICAL EXAMINER			DEPUTY MEDICAL EXAMINER			
Dr. E. W. Ditto, Jr.			215 W. Washington St., Hagerstown, Md.			Sept. 13, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			9/16/68		Dawson Cemetery		Dawson, Allegany, Md.		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
H. Wayne George Cumberland, Md.					SEP 17 1968		Charles Judge		

13603

about

02-070 514

• **Stress**

838 1 1 832

21. 10. 1942

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b, and forward to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First <b>ALICE</b>		Middle <b>CORNELIA</b>		Last <b>ROWE</b>		2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <input checked="" type="checkbox"/> 9/26 1968		2b. DATE OF ESTI- DEATH MATED Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 19	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>4/10/1875</b>	6. AGE (in years) <b>93</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 19		2d. HOUR " <input type="checkbox"/> M	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b>				Md.	
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give full address) <b>WASH. COUNTY HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during life, or when if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) <b>MARYLAND</b>		13b. CITY OR TOWN <b>WASHINGTON</b>		13c. CITY OR TOWN <b>HAGERSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RT #5</b>			
14. FATHER'S NAME First <b>GEORGE</b> Middle <b>DUSANG</b> Last <b>DUSANG</b>		15. MOTHER'S MAIDEN NAME First <b>LOUISA</b> Middle <b>BOWERS</b> Last <b>BOWERS</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, NO known)		16b. SOCIAL SECURITY NO. <b>214-54-0305</b>		17. INFORMANT <b>MRS. CATHERINE NAGY</b>		ADDRESS <b>RT. #5 HAGERSTOWN MD.</b>					
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>887X</b> IMMEDIATE CAUSE (a) <u>Pulmonary edema and</u> DUE TO, OR AS A CONSEQUENCE OF <u>Congestive heart Failure</u> (b) <u>Secondary to</u> DUE TO, OR AS A CONSEQUENCE OF <u>Fracture of femur</u> (c) <u>8 days</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48h</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>903.0</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>9-18-1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) <b>Fell in yard at home</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>		21f. LOCATION Street or R.F.D. No. <b>RT #5</b>		City or Town <b>Hagerstown</b>		County <b>WASH</b>		State <b>MD</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Edward W. Ditto, III, M.D.</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>9-27-68</b>	
EXAMINER'S NAME (Type)		<b>Edward W. Ditto, III, M.D.</b>		ADDRESS (Street, city, town, or county) <b>217 W. Washington St. Hagerstown, Maryland</b>							
23a. BURIAL, CREMATION, REBURY <b>BURIAL</b>		23b. DATE <b>9/28/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASH. MD.</b>					
24. FUNERAL DIRECTOR <b>W. J. Monument Hagerstown</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>OCT 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

2000

86/92/9

5281 1730

• • • • •

80 750 PAO IN4 ENTOM STAMPS

10321

MS. 1009



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
13593					13605					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR AM		
Hubert Artz Schindel					9 Month 29 Day 68 Year			3:50 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
male		white		11-7-1892		75 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		USA				Washington Md.				
1d. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			28 E. Washington St.			shop supt.		metal mfg		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Wash		Hagerstown				28 E. Washington St.	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
Martin L. Schindel					Ida Artz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
yes			WW I		Mrs. Margaret Schindel Hag. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon with hepatic metastasis</u> 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								4 mos		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
1538										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
7/3/68		Carcinoma of colon			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>3 July 1968</u> , to <u>29 September 1968</u> , that (I) (we) lost saw the deceased alive on <u>29 September 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE								22c. DATE SIGNED		
<u>John R. Marsh, M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								9/30/68		
22d. PHYSICIAN'S NAME (Type) John R. Marsh, M.D.					22e. ADDRESS					
					247 N. Potomac St., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
burial		10-1-1968		Rose Hill Cemetery		Hagerstown, Md.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Minnich Funeral Home Hagerstown, Md.					DATE OCT 2 1968		<u>Charles Judge</u>			

13605

Robert J. ...

11-7-1981

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13594

CERTIFICATE OF DEATH

13606

1. DECEASED-NAME (Type or print) First Middle Last <b>Augusta Eleanor Scholtz</b>			2a. DATE OF DEATH Month <b>10</b> , Day <b>1968</b> Year		2b. HOUR <b>10:10</b> P
3. SEX <b>Female</b>	4. RACE <b>White</b>		5. DATE OF BIRTH <b>8/5/96</b>		6. AGE (In years last birthday) <b>72</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b> Md.
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>domestic</b>	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Bethesda</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>5721 Grosvenor Lane</b>
14. FATHER'S NAME First Middle Last <b>unknown</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>unknown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-32-4928A</b>		17. INFORMANT <b>Mr. John Scholtz, 8117 Sublet Rd., Rockville, Md. 21150</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>180X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hydronephrosis, bilateral</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Carcinoma of cervix with extension to bladder</b> <b>1 yr.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>6 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>171X</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>August 6, 1968</b> , to <b>Sept. 10, 1968</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Sept. 10, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
22b. SIGNATURE <b>Chong Choon Han</b> DEGREE				22c. DATE SIGNED <b>9/11/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>CHONG C. HAN, M.D.</b>				22e. ADDRESS <b>Western Md. State Hospital 1500 Pennsylvania Ave., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Sept. 14, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery, Hagerstown, Md.</b>	
23d. LOCATION (City or town) (County) (State) <b>Hagerstown, Md.</b>		24. FUNERAL DIRECTOR <b>Funeral Home, Hagerstown, Md.</b>			
25a. REC'D BY REGISTRAR <b>SEP 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

13606

MINISTRY OF DEFENSE

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

13606

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13595

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13607

1. DECEASED-NAME (Type or Print) <b>MARGUERITE P. SHERMAN</b>			2a. DATE KNOWN <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <b>9 15 1968</b>			2b. HOUR <b>2:25 PM</b>				
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Sept. 27, 1934</b>	6. AGE (In years lost birthday) <b>33</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <b>9</b> Day <b>15</b> Year <b>1968</b>			2d. HOUR <b>3:15 PM</b>	
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Oaks Road</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housework</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Penna.</b>			13b. COUNTY <b>Franklin Chambersburg</b>		13c. CITY OR TOWN <b>Chambersburg</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>740 Cumberland Ave</b>			
14. FATHER'S NAME <b>Paul I STOFFER</b>			15. MOTHER'S MAIDEN NAME <b>Marguerite C. Merrill</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.
17. INFORMANT <b>Ivan S. Sherman</b>						ADDRESS <b>23 W. Main St. Waynesboro Pa.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing Injury Left chest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>8199</b> (b) <b>Rupture Diaphragm, Stomach, Spleen</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>and Skull Fracture</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immed</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>8254</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>28 AM. 9-15-1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Auto Accident</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Oaks Road</b>			21f. LOCATION Street or R.F.D. No. City or Town County State <b>3 Miles North Hagerstown Wash Md</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Edward W. Ditto, III, MD</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>9-15-68</b>			
EXAMINER'S NAME (Type) <b>217 W. WASHINGTON ST. HAG. MD.</b>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/17/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sons of Israel Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Chambersburg Franklin, Penna.</b>			
24. FUNERAL DIRECTOR <b>John O. Park</b>					ADDRESS <b>Chambersburg Penna</b>		25a. REC'D BY REGISTRAR <b>SEP 17 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



13605

13605

CHARLES W. BITTLE III  
317 N. WASHINGTON ST. HAGLE

SEP 11 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 10-64  
30M REV. 4-68

13598		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				13608					
1. DECEASED-NAME (Type or print)		First EDWIN		Middle JULIUS	Last SMEAD		2a. DATE OF DEATH Month Day Year September 7, 1968		2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan. 4, 1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Balto. City, Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington		Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Banker		12b. KIND OF BUSINESS OR INDUSTRY Retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1134 Oak Hill Ave.			
14. FATHER'S NAME First Middle Last Edwin J. Smead		15. MOTHER'S MAIDEN NAME First Middle Last Charlotte West									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) Yes		16b. SOCIAL SECURITY NO. 1916-1917 217-10-2610		17. INFORMANT Mrs. Grace K. Smead, 1134 Oak Hill Ave		Address Hagerstown, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.8 Portal Cirrhosis. DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5860 DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic Heart Disease - Diabetes Mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from May 27, 1968, to Sept 7, 1968, that (I) (we) last saw the deceased alive on Sept 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lloyd A. Hoffman		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/7/68					
22d. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		22e. ADDRESS 214 N. Potomac St. Hagerstown, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/9/68		23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md					
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home, Inc		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE SEP 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

13608

September 7, 1968

SWED

JULIUS

EDWIN

White

Male

Jan. 4, 1937 VI

Washington

U.S.A.

Belts, City, Md

Hagerstown

Washington Co. Hospital

Banker

Retired

1134 Oak Hill Ave.

Hagerstown

Washington

Maryland

West

Charlottesville

SWED

J.

Edwin

Yes

1915-1917 217-10-2010 Mrs. Grace K. Swed, 1134 Oak Hill Ave.

Hagerstown, Md

Belts, City, Md

Hagerstown, Md

217/10

Belts, City, Md

Andrew K. Coffman Funeral Home, Inc

SEP 8 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers against 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First <b>Carl</b>		Middle <b>E.</b>		Last <b>Smith</b>		2a. DATE OF DEATH Month <b>Sept.</b> Day <b>20</b> Year <b>1968</b>			2b. HOUR A <b>6:20M</b>
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>3/11/04</b>			6. AGE (In years last birthday) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>WASHINGTON</b> Md.			
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Cab Driver</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Diamond Cab</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>			13c. CITY OR TOWN <b>Cottage City</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3712 Bladensburg Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Unknown</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Martha ?</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-16-5607</b>			17. INFORMANT Address <b>Mrs. Marion E. Smith (above address)</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal hemorrhage, massive</b> (Wife) DUE TO, OR AS A CONSEQUENCE OF (b) <b>Esophageal erosion</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Aortic aneurysm</b> Approximate interval between onset and death <b>1 wk.</b> <b>unknown</b> <b>5 yrs.</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>022x Luetic aortitis c aneurysm and generalized arteriosclerosis</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>8/29</b> , 19 <b>68</b> , to <b>9/20</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Sept. 20</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Domingo A. Garcia</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									22c. DATE SIGNED <b>9/20/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Domingo A. Garcia, M.D.</b>									22e. ADDRESS <b>Western Md. State Hospital 1500 Pennsylvania Ave., Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>9/23/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Hamilton, Va.</b>			
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>						25a. REC'D BY REGISTRAR DATE <b>SEP 25 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

13609

DEPARTMENT OF HEALTH

13609

DATE OF BIRTH: 1908-10-10

DATE OF DEATH: 1908-10-10

PLACE OF BIRTH: WASHINGTON

PLACE OF DEATH: WASHINGTON

CAUSE OF DEATH: DISEASE OF THE HEART

DATE OF BURIAL: 1908-10-10

PLACE OF BURIAL: WASHINGTON

DATE OF INTERMENT: 1908-10-10

PLACE OF INTERMENT: WASHINGTON

DATE OF CREMATION: 1908-10-10

PLACE OF CREMATION: WASHINGTON

DATE OF REINTERMENT: 1908-10-10

PLACE OF REINTERMENT: WASHINGTON

DATE OF EXHUMATION: 1908-10-10

PLACE OF EXHUMATION: WASHINGTON

DATE OF REINTERMENT: 1908-10-10

PLACE OF REINTERMENT: WASHINGTON

DATE OF EXHUMATION: 1908-10-10

PLACE OF EXHUMATION: WASHINGTON

DATE OF REINTERMENT: 1908-10-10

PLACE OF REINTERMENT: WASHINGTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 4-15-64  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13598

13610

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR					
		Bessie	Pauline	Snowden	September 24, 1968		7:20P M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 27, 1880		6. AGE (In years lost birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS 2 27		IF UNDER 24 HRS. HOURS MIN. 27		
7a. BIRTHPLACE (State or foreign country) Brownsville, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.						
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co., Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Brownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last			
		Albertus	M.	Coblentz			Sarah	Hoffmaster				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) No.		16b. SOCIAL SECURITY NO. 220-54-6190		17. INFORMANT Harve De Grace, Md. Mr. Lilburn L. Snowden, Rfd. 2, Box 308								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>450X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>465X</u> (b) <u>Pulmonary emboli</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic Heart Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>William O. Rexrode M.D.</u> DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. PHYS. PHYS.												
22c. DATE SIGNED												
22d. PHYSICIAN'S NAME (Type) William O. Rexrode, M. D.				22e. ADDRESS 145 S. Prospect St. Hagerstown, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9- 28- 68		23c. NAME OF CEMETERY OR CREMATORY Brownsville Cemetery		23d. LOCATION (City or Town) (County) (State) Brownsville, Wash. Co., Md.						
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				ADDRESS		25a. REC'D BY REGISTRAR OCT 4 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

13610

September 25, 1909 7:30 PM

John H. Bass, Jr. 112 N. Main St. Boonshoro, Md. Oct 1 1909

William C. Harpole, N. D. 112 S. Prospect St. Lagersboro, Md.

John H. Bass, Jr. 112 N. Main St. Boonshoro, Md. Oct 1 1909

William C. Harpole, N. D. 112 S. Prospect St. Lagersboro, Md.

John H. Bass, Jr. 112 N. Main St. Boonshoro, Md. Oct 1 1909

William C. Harpole, N. D. 112 S. Prospect St. Lagersboro, Md.

John H. Bass, Jr. 112 N. Main St. Boonshoro, Md. Oct 1 1909

William C. Harpole, N. D. 112 S. Prospect St. Lagersboro, Md.

John H. Bass, Jr. 112 N. Main St. Boonshoro, Md. Oct 1 1909

William C. Harpole, N. D. 112 S. Prospect St. Lagersboro, Md.

John H. Bass, Jr. 112 N. Main St. Boonshoro, Md. Oct 1 1909

William C. Harpole, N. D. 112 S. Prospect St. Lagersboro, Md.

John H. Bass, Jr. 112 N. Main St. Boonshoro, Md. Oct 1 1909

William C. Harpole, N. D. 112 S. Prospect St. Lagersboro, Md.

John H. Bass, Jr. 112 N. Main St. Boonshoro, Md. Oct 1 1909

William C. Harpole, N. D. 112 S. Prospect St. Lagersboro, Md.

John H. Bass, Jr. 112 N. Main St. Boonshoro, Md. Oct 1 1909

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

13599												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												13611											
1. DECEASED-NAME (Type or print) First Middle Last <b>HAROLD CROMMER SPADE</b>												2a. DATE OF DEATH Month Day Year <b>SEPT. 4, 1968</b>												2b. HOUR P <b>11:45</b>											
3. SEX <b>MALE</b>				4. RACE <b>WHITE</b>				5. DATE OF BIRTH <b>11/12/1900</b>				6. AGE (In years at birthday) <b>67</b>				IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>				IF UNDER 24 HRS. HOURS MIN. <b>MIN.</b>															
7a. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>WASHINGTON</b>				Md.																			
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON CO. HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RETIRED CIVIL SERVICE</b>				12b. KIND OF BUSINESS OR INDUSTRY																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>PENNSYLVANIA</b>				13b. COUNTY <b>FULTON</b>				13c. CITY OR TOWN <b>WARFORDSBURG</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER <b>RURAL WARFORDSBURG</b>																			
14. FATHER'S NAME First Middle Last <b>NATHAN B. SPADE</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>EMMA C. HENDERSHOT</b>																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>204 03 3368</b>				17. INFORMANT <b>HAGERSTOWN, MD. EDNA L. BENTZ 118 LINCOLN ST.</b>																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4109</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Infarction</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few hrs</b>																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (this hospital) attended the deceased from <b>9-4-68</b> , 19 <b>68</b> , to <b>9-4-68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>9-4-68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE <b>E. R. Lanzizabal</b>				DEGREE <b>MD</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>9-6-68</b>																							
22d. PHYSICIAN'S NAME (Type) <b>E. R. Lanzizabal, M. D.</b>				22e. ADDRESS <b>300 N. Potomac St. Hagerstown, Md.</b>																															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>9/7/68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>BUCK VALLEY METHODIST</b>				23d. LOCATION (City or Town) (County) <b>RFD WARFORDSBURG FULTON PENNA.</b>																							
24. FUNERAL DIRECTOR <b>Richard J. Scarce</b>				ADDRESS <b>HANCOCK, MD.</b>				25a. REC'D BY REGISTRAR <b>SEP 11 1968</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>																							

1961

SEPT. 1, 1968

GRADE

CHROMIUM

HAROLD

11/12/1900

WHITE

MALE

WASHINGTON

X

PENNSYLVANIA U.S.A.

WASHINGTON CO. HOSPITAL RETIRED CIVIL SERVICE

MR HAGERSTON

RURAL WARFORSBURG

WARFORSBURG

FULTON

PENNSYLVANIA

EMMA O. HENDERSON

NATHAN B. GRADE

HAGERSTON, MD.

SON OF JAMES EDNA L. BENTZ 118 LINCOLN ST.

*Handwritten:* General Hagerston  
Gifted to the Post Office  
Personal attention

12-11 10 4/10

6-108

6-108

*Handwritten:* Hagerston

SON N. HAGERSTON, JR.

SON N. HAGERSTON, JR.

BOOK VALLEY METHODIST RFD WARFORSBURG FULTON

6-108

RECEIVED

SEPT 1 1968

HAGERSTON, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
13600					13612					
1. DECEASED-NAME (Type or print) First Middle Last JOHN E. SPENCER					2a. DATE OF DEATH Month Day Year Month 9 Day 3 Year 68			2b. HOUR P 2:30 M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11/11/1874			6. AGE (In years last birthday) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.				
10. CITY OR TOWN OF DEATH HAGERS TOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AVALON MANOR			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MECHANIC			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE N.J.			13b. COUNTY 13c. CITY OR TOWN Wildwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER -----			
14. FATHER'S NAME First Middle Last Hiram Spencer			15. MOTHER'S MAIDEN NAME First Middle Last Melinda Royer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Clarence A. Spencer Cumberland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4339 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332x									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo. yrs.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-2</u> , 19 <u>68</u> , to <u>Sept. 1</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>AUG. 30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Lloyd A. Hoffman</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 9/3/68					
22d. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>					22e. ADDRESS <u>214 N. Potomac St. Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/6/1968		23c. NAME OF CEMETERY OR CREMATORY Burns Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Waynesboro Franklin Pa.			
24. FUNERAL DIRECTOR <u>S. Martin Roe</u> ADDRESS Waynesboro, Pa.					25a. REC'D BY REGISTRAR DATE SEP 6 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



1941

RECEIVED

1941

RECEIVED

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

13601

Item 5 Film G-102-158

## CERTIFICATE OF DEATH

13613

1. DECEASED-NAME (Type or print) <b>THOMAS RAY SPENCER</b>			2a. DATE OF DEATH Month <b>September</b> Day <b>19</b> Year <b>1968</b>			2b. HOUR <b>10</b> <sup>P</sup> <sub>M</sub>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 31 1894</b>		6. AGE (In years last birthday) <b>74</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash County Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bell Tel. Co</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>West Virginia</b> COUNTY <b>Greenbrier</b>		13b. CITY OR TOWN <b>Richwood</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>None</b>	
14. FATHER'S NAME First Middle Last <b>Charles Spencer</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Lydia R. Hinkle</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>W.W.#1</b>		16b. SOCIAL SECURITY NO. <b>271-01-0179</b>		17. INFORMANT Address <b>Dr Charles C. Spencer 2209 Rowland Rd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1890</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Left Kidney with metastases</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>180X</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>68</b> , to <b>Sept</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Sept 19</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles C. Spencer</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Sept 20, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Charles C. Spencer M.D.</b>				22e. ADDRESS <b>145 So Prospect St Hagerstown Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/22/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Morningside Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Renick Greenbrier Co W. Va</b>	
24. FUNERAL DIRECTOR <b>Hagerstown Md. Andrew K. Coffman Funeral Home Inc</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13813

September 19 1966 10

SPENCER

RAY

THOMAS

VA

May 31 1966

White

Male

X

Washington

USA

W. Va.

Supervisor

West Virginia State Police

West Virginia State Police

Home

Richwood

Charles Spencer

Lydia R. Hinkle

271-01-0179 or Charles C. Spencer 2709 Rowland Rd

West Virginia State Police

Charles C. Spencer R.D. 141 20 Prospect St West Virginia

Official 9/28/66 Morganside Cemetery, Taylor or Charles C.

Andrew K. Coffman Funeral Home, Inc

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

230

13602		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH								13614	
1. DECEASED-NAME (Type or print)			First Middle Last <b>WILLIAM H. STARLIPER</b>			2a. DATE OF DEATH Month Day Year <b>Sept 5 1968</b>			2b. HOUR <b>5:00 AM</b>		
3. SEX <b>Mle</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Dec. 31, 1881</b>		6. AGE (In years last birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Mercersburg, Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>			Md.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Co. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Gen. farming</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Pa.</b>		13b. COUNTY <b>Franklin</b>		13c. CITY OR TOWN <b>Mercersburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>R.D. 3</b>			
14. FATHER'S NAME First Middle Last <b>Thomas H. Starliper</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Ellen Myers</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>191-18-3534</b>		17. INFORMANT Address <b>Elmer W. Starliper Mercersburg, Pa.</b>				<b>R.D. 3</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pulmonary embolism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <b>4201 Met. Hypertension</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 min</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR/A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 4, 1968</b> , to <b>Sept 4, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept 4, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>E. L. Anderson M.D.</b>		DEGREE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.		DATE SIGNED <b>9-5-68</b>							
22d. PHYSICIAN'S NAME (Type) <b>E. L. Anderson M.D.</b>		22e. ADDRESS <b>306 G. St., Hagerstown, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE <b>9/9/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Mercersburg, Pa.</b>					
24. REGISTRAR <b>T. K. Springer</b>		ADDRESS <b>Mercersburg, Pa.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

13814

13802

RECORDS OF THE

STATION

STATION

H.

38

Jan. 11, 1891

white

Mie

Washington

X

USA

Concord, Pa.

Harersown

Wash. Co. Mary.

Patrol

Franklin Harersown X N.D.S.

Pa.

Mary Ellen Myers

Thomas H. Scribner

191-10-333 James W. Scribner Harersown, Pa.

No

Concord, Pa.

Calverton, Pa.

191-10-333

SEP 11 1891

Concord, Pa.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-31-68 mt. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 film 406&22a  
10-31-68 mt

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13615

1. DECEASED NAME (Type or Print) <b>WILSON ANDREW STARLIPER II</b>			2a. DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>Sept. 29, 1968</b>			2b. HOUR A. <input type="checkbox"/> M. <input type="checkbox"/> <b>7:15 A.</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>July 16 1968</b>	6. AGE (in years last birthday) YRS. <b>2</b> MONTHS <b>2</b> DAYS <b>13</b> HOURS <b>MIN.</b>	IF UNDER 1 YEAR MONTHS <b>2</b> DAYS <b>13</b> HOURS <b>MIN.</b>		IF UNDER 24 HRS. HOURS <b>MIN.</b>		2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>Sept. 29, 1968</b>	2d. HOUR A. <input type="checkbox"/> M. <input type="checkbox"/> <b>8:15 A.</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>			Md.
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Hagerstown</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Washington</b>		13c. CITY OR TOWN <b>R #3</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Garis Shop Road</b>	
14. FATHER'S NAME First <b>Wilson A</b> Middle <b>Starliper Jr</b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>Jane</b> Middle <b>Stuck</b> Last <b></b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>None</b>		17. INFORMANT <b>Wilson A. Starliper Jr</b>			ADDRESS <b>R #3</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pending</b> <b>Interstitial Pneumonitis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>484x</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>492x</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
19a. DATE OF OPERATION <b>492x</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b></b>		City or Town <b></b>		County <b></b>	State <b></b>
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>D. W. Ditto</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>Sept. 30, 1968</b>			
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county) <b>215 W. Washington St., Hagerstown, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/1/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dunkard Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Broadfording Wash Co Md</b>			
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc</b>				25a. REC'D BY REGISTRAR <b>OCT 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

13815

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10/1/68

STATE OF MARYLAND  
HEALTH DEPT.



WILSON ANDREW STARLIPER II

White July 10 1968 2 13

Washington

USA

Maryland

Infant

Washington

X Girls Shop Road

Washington H. Spotswood

Maryland

John Stock

Wilson A. Starlipper Jr

W. H. S.

Wilson A. Starlipper Jr Washington MD  
Girls Shop Road

None

no

Brookford Home Co MD

Deckerd Cemetery

Washington MD

8 April

Andrew K. Colman Funeral Home Inc

10/1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
13604 CERTIFICATE OF DEATH 13616										
1. DECEASED-NAME (Type or print) <b>KATHARINE SHEPHERD STEHL</b>					2a. DATE OF DEATH Month <b>2</b> Day <b>68</b> Year			2b. HOUR <b>10 a.m.</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JULY 29, 1879</b>		6. AGE (In years last birthday) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b> Md.				
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON COUNTY HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>HAGERSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>830 POTOMAC AVE.</b>	
14. FATHER'S NAME First Middle Last <b>JAMES BUCHANAN LUCAS</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>ELLEN BROOKS LUCAS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>WALTER B. STEHL, JR. 100 Address BLINTON AVE HAGERSTOWN, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-Sclerotic Heart Disease</b> <b>5 yrs</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>General Arterio-Sclerosis</b> <b>10 yrs</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4300</b> <b>Mitral Insufficiency, Ventricular Hypertrophy.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>Aug 22, 1968</b> to <b>Sept 2, 1968</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Sept 2, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(We)</del> <b>(did)</b> <del>(did not)</del> view the body after death										
22b. SIGNATURE <b>JACK HENSON BEACHLEY, M.D.</b>						22c. ADDRESS <b>221 W WASHINGTON ST., HAGERSTOWN, MD.</b>		22d. DATE SIGNED <b>9/3/68</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>9/5/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASHINGTON MD.</b>			
24. FUNERAL DIRECTOR <b>Charles M. Rouzon</b>					ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

13616

13616

4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 13 Film G404 10/1/68									
13605									
13617									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
PAUL			H. STORK			September 2 1968			10:35 A/M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years birthday)		IF UNDER 1 YEAR MONTHS DAYS	
male		white		9-21-1909		58		YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			Md.
Pa.		USA				WASHINGTON			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during last year or last 12 months, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
HAGERSTOWN			WESTERN MD. STATE HOSPITAL			electrician			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13e. STREET AND NUMBER
Md.			Hagerstown			YES <input type="checkbox"/> NO <input type="checkbox"/>			213 Washington Street
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Harry H. Stork			Alice Bennett						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
no						Benjamin Stork			Tera Alta, W. Va.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u>									1 day
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Emphysema, Lung</u>									6 yrs.
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
52771									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 23, 1968</u> , to <u>Sept. 2, 1968</u> , that (I) (we) last saw the deceased alive on <u>September 2, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE								22c. DATE SIGNED	
Domingo A. Garcia								September 2, 1968	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
DOMINGO A. GARCIA						Western Maryland State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		9-4-68		Finleyville Cemetery		Finleyville, Pa.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Minnich Funeral Home Hagerstown, Md.						SEP 5 1968		Charles Judge	



13615

CENTRAL OF MARY

13603

WASHINGTON

9-21-1909

white

male

184

1.4

WESTERN MD. STATE HOSPITAL

HARRISBURG

HARRISBURG

near

A.

Alice Adams

Harry E. George

Edw. and George

No

1909 9-21-1909

Station Hospital Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13606		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		13618	
Item #6, Film G404		9/20/68 km		CERTIFICATE OF DEATH	
1. DECEASED-NAME (Type or print) First Middle Last <b>Leonard Eldridge Vance</b>			2a. DATE OF DEATH Month Day Year <b>September 14, 1968</b>		2b. HOUR <b>7:35</b> M
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>3-1-1897</b>		6. AGE (In years) <b>71</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1021 Mt. Aetna Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Steeple Jack</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Wash.</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>1021 Mt. Aetna Road</b>
14. FATHER'S NAME First Middle Last <b>Eldridge B. Vance</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Dosha Caldwell</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>214-16-1018</b>		17. INFORMANT Address <b>Mrs. Mary Vance Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4109</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Sclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 yrs.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 Hrs.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>67</b> , to <b>Sept. 14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Sept. 14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Arthur Riego</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9-15-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>ARTHUR RIEGO</b>		22e. ADDRESS <b>119 E. Antietam Hagerstown</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9-17-1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home Hagerstown, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>SEP 18 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

13618

RECEIVED OF DEATH

13618

James E. Vance  
Elizabeth Vance  
James E. Vance

1-1-1887

White

White

Washington

Age

Married

James E. Vance  
Elizabeth Vance  
James E. Vance

1-1-1887  
1-1-1887  
1-1-1887

James E. Vance

Elizabeth E. Vance

1-1-1887  
1-1-1887  
1-1-1887

1

1

James E. Vance  
Elizabeth E. Vance  
James E. Vance

James E. Vance  
Elizabeth E. Vance  
James E. Vance

James E. Vance  
Elizabeth E. Vance  
James E. Vance

James E. Vance  
Elizabeth E. Vance  
James E. Vance

1-1-1887  
1-1-1887  
1-1-1887

James E. Vance  
Elizabeth E. Vance  
James E. Vance

1-1-1887

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
John Robert Wagner						Month Day Year September 15, 1968			7:20 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR
male		white		5-16-1900			68 YRS.		MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		USA				Washington Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital write street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown			Wash. County Hospital			Mech. Engineer			Sand Blast
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Wash.		Hagerstown			441 Pangborn, Blvd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last John F. Wagner			First Middle Last Hannah Noriconk						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW I			214-09-5978		Mrs. E. Louise Wagner Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>157.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>probable Carcinoma of pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>157x arteriosclerosis Heart Disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/12</u> , 19 <u>68</u> , to <u>9/15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9/15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DEGREE		22d. PHYSICIAN NAME (Type)		22e. ADDRESS		22f. DATE SIGNED	
<u>Donald E Martin</u>		<u>MD</u>		Donald E. Martin, M.D.		363 S. Cleveland Ave., Hagerstown, Md.		<u>9/16/68</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		9-18-1968		Rest Haven Cemetery		Hagerstown, Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Minnich Funeral Home Hagerstown, Md.				DATE SEP 18 1968		<u>Charles Judge</u>			

13619

John Robert Wagner  
Male  
White  
1-1-1900  
Washington  
Baltimore  
West. County Hospital  
West. Engineer  
Baltimore, Md.  
John A. Wagner  
1-1-1900  
Baltimore, Md.

1-1-1900  
Baltimore, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR P.M.	
ALBERT BLOOM WAKENIGHT						Sept 7 1968		10.30 <sup>M</sup>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Aug 2 1900		68 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Maryland		U.S.A.				Washington		Hagerstown	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
665 Pin Oak Rd		Real Estate Developer							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		665 Pin Oak Road	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Leslie T. Wakenight			Hattie Bloom						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No ---			577-09-6173			Mrs Helen E. Wakenight			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of arteriosclerotic aneurysm of thoracic aorta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>11 years</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>443X</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-27, 1958</u> , to <u>9-7, 1968</u> , that (I) (we) last saw the deceased alive on <u>9-7, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John H. Hornbaker M.D.</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>9-9-68</u>	
22d. PHYSICIAN'S NAME (Type) John H. Hornbaker				22e. ADDRESS <u>154 West Washington St., Hagerstown, Md. 21740</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		9/10/68		Rose Cemetery		Hagerstown Wash Co Md			
24. FUNERAL DIRECTOR <u>Hagerstown Md.</u> <u>Andrew K. Coffman</u>				ADDRESS <u>Funeral Home Inc</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 13 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

19650

10.30

Sept 7 1965

WAKENIGHT

BLOOM

ALBERT

33

Aug 2 1960  
XX

White

Male

Washington

U.S.A.

England

Real Estate Developer

805 Elm Oak Rd

Agrestown

805 Elm Oak Road

Washington D. Agrestown

England

Wattie Bloom

Leslie T. Wakenight

377-09-0173 Mrs Helen S. Wakenight

---

6

Andrew K. Coffman Funeral Home Inc  
Agrestown Pa  
Sept 17 1965  
Burial 9/19/65  
and Cemetery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
Rose Ellen Warrenfeltz					September 24, 1968		8:00A M		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
Female	White		June 8, 1879		89 YRS.		3 16		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Rohrersville, Md.		U. S. A.				Washington Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Boonsboro, Md.		Fahney- Keedy Mem. Home		Housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Boonsboro				210 N. Main St.	
14. FATHER'S NAME		First Middle Last		15. MOTHER'S MAIDEN NAME		First Middle Last			
Tilghman		Norris		Annie		Manges			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No.		None		Mrs. Roscoe H. Hammond, Keedysville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic heart disease</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>2 months</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>4201</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
				Mag 2, 1968, to Sept 24, 1968, that (I) <del>was</del> last saw the deceased alive on <u>Sept 23</u> , 1968, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>did not</del> view the body after death.					
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<u>G. W. Heckler M.D.</u>						Sept 24, 1968			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Boonsboro, Md.									
23a. BURIAL, CREMATION, or other disposition (City)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		9-26-68		Boonsboro Cemetery		Boonsboro, Wash. Co., Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John H. Bast, Jr.		112 N. Main St. Boonsboro, Md.		SEP 30 1968		Charles Judge			

13621

DEATH

13621

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

13610		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				13622					
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR				
Ruby Lee Waugh					9 Month 1 Day 68 Year		11:30 AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
female		white		2-19-47		21 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		USA				Wash.		Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Wash. Co. Hospital		secretary		auto dealer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Wash.		Sharpsburg							
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
George L. Harsh					Violet Jesop						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
no				Michael Waugh		Sharpsburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anaplastic Carcinomatosis (site of origin)</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1992</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>17 June</u> , 19 <u>68</u> , to <u>1 Sept</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>1 Sept</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>W. N. FENDER</u> M.D. DEGREE		22c. DATE SIGNED <u>3 SEPT. 1968</u>		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. LOCATION			
				W. N. FENDER		218 N. Potomac St., Hagerstown, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
burial		9-4-68		Funkstown Cemetery		Funkstown, Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Minnich Funeral Home Hagerstown, Md.				SEP 5 1968		J. Charles Judge					



13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

13025

## CERTIFICATE OF DEATH

13611

13623

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <b>Nathaniel George Wilson</b>			2a. DATE OF DEATH Month <b>September</b> Day <b>7</b> Year <b>1968</b>			2b. HOUR M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 22, 1891</b>		6. AGE (In years lost birthday) <b>77</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Frederick, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>R # 4</b>		14. FATHER'S NAME First Middle Last <b>Christopher Nathaniel Thomas Wilson</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Georgette George Etta Smith</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>214-09-6685</b>		17. INFORMANT <b>Mrs. Mary Lou Mayes</b>		1800 Virginia Ave.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac insufficiency</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4200</b> (b) <b>Arteriosclerotic heart disease &amp; Cor Pulmonale</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Pulmonary emphysema</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 68</b> , 19__, to <b>present</b> 19__, that (I) (we) last saw the deceased alive on <b>8/7/68</b> 19__, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Nemo R. R. R.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/9/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>145 S. Prospect St.,</b>				22e. ADDRESS <b>Hagerstown, Md. 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/10/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown-Washington-Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. C. Horst</b>		ADDRESS <b>Rest Haven Funeral Chapel Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

1362

5

2006/07/04

also

23/04/2011

1921, SS 1014

2007-08-01

10/10/2006

2002-2003

பிரதீபம்-120, டிசம்பர் 2007, பக்கம்-10

30100100

2001.01.01

250214

2000年12月10日

2000

• [www.smoke.gov](http://www.smoke.gov)

STP-0-0087 (Rev. 1-65) 2800-10-101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

13612										13624									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13624									
CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Last <b>CHARLES WINGER ZIMMERMAN</b>					2a. DATE OF DEATH Month Day Year <b>9 26 68</b>					2b. HOUR M <b>M</b>				
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>4.16.1874</b>			6. AGE (In years last birthday) <b>94</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) <b>HANCOCK MD.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>WASHINGTON</b> Md.										
10. CITY OR TOWN OF DEATH <b>HANCOCK</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RETIRED FARMER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>FRAMING</b>										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>WASHINGTON</b>			13c. CITY OR TOWN <b>HANCOCK</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>205 PENNA. AVE.</b>							
14. FATHER'S NAME First Middle Last <b>• HENRY C ZIMMERMAN</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>SARAH WINGER</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214.48.4305</b>			17. INFORMANT Address <b>WALTER PETERMAN CLEARSPRING MD.</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4109</b> IMMEDIATE CAUSE (a) <b>Myocardial infarct</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>5 wks</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 wks</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4201</b>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 12, 19 68</b> to <b>Sept 26, 19 68</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <b>L.M. Shaffer</b>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>9/27/68</b>													
22d. PHYSICIAN'S NAME (Type) <b>L.M. SHAFFER</b>			22e. ADDRESS <b>HANCOCK MD.</b>																
23a. BURIAL, CREMATION, or other disposition <b>BURIAL</b>			23b. DATE <b>9.28.68</b>			23c. NAME OF CEMETERY OR CREMATORIUM <b>SIDELING HILL BAPTIST</b>			23d. LOCATION (City or Town) (County) (State) <b>FULTON COUNTY PENNA.</b>										
24. FUNERAL DIRECTOR <b>Howard F. Kline</b>			ADDRESS <b>Hancock Md</b>			25a. REC'D BY REGISTRAR DATE <b>OCT 2 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>										

1882

1882

(4)

(5)

(6)

(7)

(8)

(9)

88	56	0	ZIMMERMAN	WINGER	CHARLES
88	56	0	W. 16. 1879	WHITE	MALE

WASHINGTON	X	U.S.A.	HANDOOK NO.
------------	---	--------	-------------

RETIRED FARMER	HOME	HANDOOK
----------------	------	---------

505 PENNA. AVE.	X	WASHINGTON	HANDOOK	NO
-----------------	---	------------	---------	----

WINGER	SARAH	ZIMMERMAN	WINGER	WENBY
--------	-------	-----------	--------	-------

WALTER PETERMAN CLEARSPRING NO.	514. 18. 1892	WASHINGTON	HANDOOK	NO
---------------------------------	---------------	------------	---------	----

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON